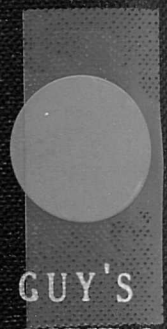

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

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The charge for binding in blue, with the Arms of the Hospital in gold will be ONE SHILLING AND SIXPENCE.

Calendar of Coming Events.

Jan., 1903.

Sat. 3.—Messrs. Symonds and Steward's take-in; Drs., H. H. Carter and B. H. Stewart; Cl., E. Faulks.
G.H.R.F.C., I., Old Leysians, away.
II., Surbiton, home.
G.H.A.F.C., I., Old Reptonians.
II., Sevenoaks School, away.

Wed. 7.—1.30 p.m., Clinical lecture by Mr. Jacobson.

Thur. 8.—Messrs. Lucas and Lane's take-in; Drs., M. G. Louisson and H. F. Bell-Walker; Cl., T. Morland-Smith.

Sat. 10.—1 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., I., Catford Bridge, away.
II., Beckenham, away.
III., Old Alleynians, home.
G.H.A.F.C., I., Ewell, away.
II., Ewell, II., home.

Mon. 12.—1.15 p.m., Clinical lecture by Dr. Galabin.

Wed. 14.—G.H.P.P.S., Clinical meeting, 8 p.m.
1.30 p.m., Clinical lecture by Mr. Jacobson.
G.H.A.F.C., I., Eastbourne, away.

Thur. 15.—Messrs. Golding-Bird and Dunn's take-in: Drs., J. F. Rey and A. E. F. Kynaston; Cl., C. R. Howard.

Sat. 17.—1 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., I., Rosslyn Park, home.
II., Polytechnic, away.
G.H.A.F.C., I., Beckenham, home.
II., Beckenham II., away

Guy's Hospital Gazette.

JANUARY 3, 1903.

Impacted Foreign Body in the Bronchus.

CLINICAL LECTURE BY MR. GOLDING-BIRD.

November 19th, 1902.

Short abstract of the case of Impacted Foreign Body in the Bronchus, read at the previous lecture:—

X. B., Cornelius ward, 27th September, 1902, to 5th November, 1902. Admitted third day after having a small piece of wood (size of tip of his little finger) down the trachea. In himself he seemed very well, complaining only of a feeling of something "stopping up his chest." Physical condition:—Deficient air entry everywhere left lung, puerile breathing on right ride. Slight dull pain below left sterno-clavicular joint. Slight spasmodic cough. Tracheotomy; attempts with snare and various forceps to remove foreign body failed. At first attempt muco-pus came up into the wound with a little blood. At one time body thought to be seen for a moment in trachea, but if it were it was sucked back at once. On October 15th the tracheotomy wound was allowed to close, the child having gone through a slight septic pneumonia on left side, and before his discharge Dr. Bryant, who kindly examined him, was of opinion that fibroid changes were commencing in the left lung. Three weeks later he came up still looking quite well, but with history of spasmodic cough with expectoration at night.

GENTLEMEN,—Though my clinical lecture last week was on the case of a boy who had a piece of wood impacted in his bronchus, there were so many preliminary and general considerations to be discussed that we hardly reached the essence of the subject. I confine myself, therefore, to-day, strictly to the case, and whilst studying the symptoms and treatment of foreign bodies in the lung we shall incidentally get introduced to the surgery of lung cavities generally.

As I mentioned last week it is important in getting out the patient's history to try and discover the nature of the body "swallowed": (as patients generally call it) for the shape and nature of the substance as well as its exact position in the bronchus, largely determine the present and future behaviour of the case. When the foreign body blocks the bronchus completely it is certain that an immediate effect will be imprisoned air in the piece of lung to which that bronchus leads, with at first hyper-resonance over that area of the lung, absence of breath sounds, diminished vocal fremitus, while pain may or may not be present.

Then, the foreign body may be a tight fit, but not be actually fixed; hence, especially if smooth and rounded, it will act as a ball valve, allowing egress but not entrance of air, with the result that the part of the lung to which that bronchus leads will eventually collapse, a condition technically known as one of atelectasis, or imperfect expansion. As you can well imagine the symptoms of this condition, both subjective and objective, will mainly depend upon the amount of lung involved.

Or the foreign body may fit so imperfectly as to allow a passage of air, enough to prevent lung collapse, but not enough for physiological purposes, nor enough to give normal stethoscopic signs. This was the case in the patient who is the subject of my lecture. My house-surgeon, Mr. Brown, reported to me that the signs present on auscultation on his admission were those of a limited air entry over a defined area of the left lung; but there was neither complete percussion dulness, nor was there an absence of all breath sounds, but a "hissing" sound as of a narrowed air way was quite distinguishable.

The foreign body may happen to be hollow, and whilst capable of producing, if allowed to remain, many of the serious after consequences that I shall mention, it may, at the time of the case being first seen, give rise to no physical signs, inasmuch as the air can pass readily through it. Such a case was that of a woman, æt. 74, under my care in 1890, who fifty-one years before was tracheotomised by Mr. Hilton, and had worn a silver tube ever since, as the stenosis of the larynx for which he had operated on her could not be cured. The stem of the tube broke from the silver shield and slipped down into the *right* bronchus. (This we did not know until the operation.) She was dyspnœic and in much distress, not to say a great fright! On auscultation no air was found entering the *left* lung. What had happened was that the curved silver tube had entered the right bronchus for a short distance, but the part in the trachea lay across the mouth of the *left* bronchus, completely blocking it, whilst the right bronchus in which it really lay was pervious to air via the tube itself! By rather enlarging the old tracheotomy wound I was quickly able to remove the obstruction. You must also remember the foreign body may be liquid, though as such it will not remain in the bronchus, but get at once into the parenchyma of the lung and beyond the aid of surgery. The liquid may be beef-tea improperly administered to an insensible patient, or blood or pus from an artery or abscess.

Again, the body may be movable up or down right up as far as the glottis. That is a very serious thing, perhaps one of the most serious things that can happen. In any effort of coughing the body may be forced against the glottis, or stick in or just below the glottis, or so produce spasm of the glottis as to cause death by suffocation. So that a case in which there is a foreign body that moves up as far as the glottis, is one which calls for immediate operation by tracheotomy.

Given that you know what the foreign body is, what are you to do? The treatment as far as the surgeon is concerned is practically the same wherever the foreign body is, and that is, to try and get it out—to do exactly what you would do if the foreign body were in the trachea. The only difference is, you must do a low tracheotomy instead of a high one. If the body were wedged somewhere near the glottis, by a high tracheotomy you would get it out easily, but if it were in a bronchus or below the level of the sternal notch, such an operation would be most ill-advised. In this latter case by doing a tracheotomy low down you are so

much nearer the object of your search and have a better chance of seizing it if it becomes a matter of "groping" for it.

Having performed tracheotomy then you must not insert a tracheotomy tube, both because it is bad surgery ever to put in a tracheotomy tube immediately the trachea has been opened, for whatever cause you may have done it, and because it will prevent the foreign body being coughed out by the patient or sought for by instrumental means.

Either insert a silk each side of the tracheal wound to act as retractors (it can be also united to the skin), or employ some form of dilator, such as this self-retaining bivalve one, the blades of which travel parallel on right and left handed screws, and which I introduced many years ago. It is not at all unlikely that at this stage of the operation the patient may cough the foreign body up, if not out; hence be ready with forceps to seize it should it appear. By inversion of the patient (if a child) and tickling the trachea with a feather, coughing may be induced, should the patient be otherwise inactive from the anæsthetic. The quality and shape of the foreign body, if known, will perhaps be the best guide as to whether at all, or for how long, these efforts at auto-expulsion should be favoured, a smooth and rounded body being likely to be now ejected, whilst a jagged one will hardly be moved.

The surgeon now must search in the bronchus taking as his guide the physical signs observed before narcosis. First he can use a long silver probe (flexible) and may be fortunate enough to locate the body exactly, then he employs various prehensile instruments. (X-rays will, of course, show metallic bodies and some others with ease, but location by their means is not exact enough for the surgeon.)

The simplest is a long loop of soft silver wire (or of fine piano (steel) wire), and by its means the body may be caught and brought up. If, however, the body be jagged this method is more likely to injure the bronchus, as it only allows of direct upward traction, and not of any rearrangement or turning of the body.

The various forms of forceps come next. I myself have found very useful Toynbee's rectangular aural polypus forceps, the only limit to their usefulness here being their shortness, but they will reach the entrance at least of each bronchus, then almost any form of slender, long, slightly curved forceps can be employed, of which you see a variety on the table. An ordinary pair of dressing forceps will answer in many cases. Of course, other things being equal, the better equipped the surgeon is with a choice of forceps the more likely is he to succeed in removing the obstruction; yet, where the simpler means have failed, I have not found myself more subtle instruments so very useful. There is, of necessity, a limit to the utility of forceps in the distance down the bronchus the body may be, or it may be it lies in a lateral branch, and is then quite inaccessible from above.

If the foreign body be either removed by the surgeon or coughed out at the first sitting, well and good. I have no more to say upon that point; but if, as in our boy's case, it still remains impacted after all efforts at removal, a train of symptoms and complications may be expected which now must be our special study.

I may here remark, as I told you last time, that the boy did not come up to the hospital till the third day, and that from his own account it was a rough piece of wood that had "gone down." It is, therefore, hardly strange that we failed to recover it, for amongst other causes of fixation would certainly be that of its swelling like a "sponge tent." The report as I read it you, seems to imply that it may have moved or even got into the right bronchus from the left, but I must say, on the whole, I am very doubtful about this.

What follows, then, if the foreign body remains in the bronchus?

Firstly a septic pneumonia of greater or less extent will certainly be started (and prior to that in the case of a body acting as a "ball valve" will be atelectasis), and then the body may perforate the lung and cause a superficial abscess, or it may cause an empyæma, and on the opening of either the body may be perhaps discovered.

Where these acute septic conditions do not occur, a slow change of fibrosis in the lung may take place; whilst the result which is

perhaps of all the most interesting to the surgeon, and partly the result of septicism, partly of physical forces, is that of bronchiectasis.

As to pneumonia, to us as surgeons it does not matter much. Of course it matters, because it jeopardises the life of the patient, but we can do nothing in that condition except calling in the physician to aid us. Septic pneumonia will the sooner be started if a body that is septic is swallowed. This boy ran through a septic course and a certain area of dulness was found in the lung two or three days after the foreign body was swallowed. The temperature ran up to 102·2°, it touched 103° on one occasion, as it might do for any septic wound anywhere. The use of pneumonia to us surgeons is to show us almost certainly that we have not removed the offending body.

Sometimes the lung is perforated by the foreign body. That is more likely to occur if the body is either a very septic thing, likely to produce rapid septic disorganisation, or if it is a body of such a shape and size as to be able to pierce its way.

Godlee has quoted a case where a nail was "swallowed" and made its way through the lung and into the pleural cavity, causing an abscess there. The instance I am now going to give you is very curious. Twenty-five years ago I had a foreign body sent to me by an old Guy's man, who enquired what I thought it was. It was of a grey colour, covered with pus. I was asked, "Is this a piece of rib?" It was a curious question to ask, because the body was quite soft. It certainly was not rib.

I asked the history of the case, and learnt that this foreign body had come from an abscess opened under the breast of a young girl about twenty years of age; she had been suffering from "consumption" for a year, and was not expected to live long. She had offensive expectoration, and had all the signs of breaking up of the lungs. But an abscess formed under the right breast, and when it was opened out came this supposed piece of rib. On examining it I found it was an ear of grass like wild barley, which children are rather apt to put up their sleeves, and which, when the arm is outstretched backwards and forwards, makes its way further up. When this girl was told what the body was, she remembered that a year before she had been playing with this grass, and had put an ear of it in her mouth, and it had disappeared. Curiously it had not produced any symptoms at the time, but after a year had resulted in an abscess. It had apparently got into the lung and produced bronchiectasis, and given rise to symptoms of phthisis, and in due course made its way out. It must have produced adhesions round the parietal and visceral pleura. After the abscess was opened and the body came out, the girl at once improved. The other day Dr. Bryant had amongst his out-patients a boy with an abscess in about the same place as the girl I have mentioned, and out of the abscess came a piece of grass which had been swallowed a fortnight before. Dr. Bryant, who kindly allows me to refer to her case, is like myself puzzled at the rapidity with which the grass reappeared; but there seems no reason for doubting the boy's history. I have already mentioned that foreign body may cause empyema or suppurative pleurisy by making its way through the lung into the pleural cavity. Therefore, if you have a history of the possibility of a foreign body having gone the wrong way, and if, after a few weeks, there is a story of the child having taken ill, with evidence of pleurisy, bear in mind that a foreign body may be there. If the case is one of empyema, you should treat it in a particular way. With one exception we do not as a rule tap an empyema. That is not sufficient for a cure. In almost all cases we are very free with the knife. We open between the chest wall, then drain the chest. But in a case of this kind, if you have reason to think there is a foreign body present, you must do something to get the foreign body out, or allow it to come out after the operation. Therefore, I would certainly urge you in all cases to take out a piece of rib. We often do that in cases of an ordinary empyema. This will leave an aperture through which you can search for the foreign body, or through which it may be expelled.

As to the fibroid changes induced by the foreign body (as in the specimen shown) it may

be anticipated where acute or subacute inflammatory symptoms are slight or do not appear, and especially where atelectasis has occurred. It has but little interest for us as operating surgeons, we can do nothing for it, but as an aid in diagnosing the character of the condition known as bronchiectasis it is very valuable, as I will explain directly.

As with pneumonia so with fibroid change, each warns the surgeon that the foreign body is probably still unremoved; and whilst the former and subsequent septic changes may open a way for surgical interference, the latter, as I have said, does not do so.

To us, I think the most interesting result of a foreign body in the bronchus is bronchiectasis, or the dilatation of a bronchus; it is that that concerns us as surgeons. Let us consider the conditions that we want to get in order to produce bronchiectasis. First of all, why do we not get a condition of bronchiectasis under ordinary circumstances of life, and why, when we breathe, should the lung expand and not the bronchi? The answer is because there is bulk of lung enough to fill up the chest space, and because the bronchi are so strengthened with a coat of mail in the form of cartilage, that it would be exceedingly difficult under that amount of pressure to cause them to stretch. So that other circumstances are required to cause them to stretch. Here is a case (specimen shown) of a softened bronchus. Nothing will do more, I believe, to produce such a bronchus than a septic foreign body. A septic inflammation of the bronchus produces softening, and the bronchus will then feel the air pressure much more than under normal conditions. If you add to that, that part of the lung is not expanding, and therefore that in breathing you want expansion or something else to fill up the chest space, then a softened bronchus will get expanded like a piece of lung tissue.

Another thing that produces this bronchiectasis is increase of the expanding force within. The force of expiration is a force which, under circumstances of a foreign body, is very likely to produce a dilated bronchus. Supposing that the foreign body does not completely block the bronchus, but lets a certain amount of air pass, when the patient coughs and makes a violent effort at expiration, the air will find exit with difficulty and in doing so will dilate the bronchus just behind the obstruction.

A foreign body within the bronchus will also give rise to a local collection of muco-purulent fluid, and supposing a cavity has begun to form and there is sufficient fluid present, it will give rise to continued softening, and by its pressure, and also by its weight help to dilate the bronchus. Thus the continued presence of fluid in a dilated bronchus helps still further to increase its size.

In all these instances that directly or indirectly produce bronchiectasis, I have spoken as if there were but one dilatation of the bronchus—just beyond the obstruction. And such is often the case; and, indeed, it is the only case in which good can be expected from surgery.

But there is yet another way of inducing bronchiectasis in connection with a foreign body in which a sacculated space is left, or several dilatations, one below the other, a state of affairs in which surgery is of little if any benefit. This is by the fibroid change in the lung that I have already mentioned. Fibrous tissue, wherever it appears, contracts slowly and distorts, and, as a burn scar distorts the face, so does a fibroid lung parenchyma pull upon and distort a softened bronchus, and with the other conditions (more or less) above mentioned help to dilate the bronchus; but, inasmuch as the pull on the one side of the bronchus is both distributed over a varying length and is as well irregular in the force and direction of its action, an irrregular sacculated dilatation results, looking, as in this specimen, as if so many marbles had been impressed into the bronchus and left their shape at varying intervals down it.

Such a condition is not benefited by surgery for obvious reasons, as is a single egg-shaped cavity, even if it could be located with the correctness the surgeon requires; and if any attempt were made, on the lines to be laid down, to open such a bronchus with a view of finding the foreign body, the chances of success would evidently be very small.

In any case, therefore, of bronchiectasis, in which the question of operation is entertained, every means must be employed to determine first whether the single or sacculated form is present.

I have been assuming that serious mischief must in every case follow the impaction of a foreign body in the lung; but it is quite possible —though not so likely as in other parts of the body—that it may become quiescent and encysted. This applies especially to smooth metallic substances, such as bullets; but porous and jagged bodies, from their septicity and roughness, are infinitely less likely to do so. Moreover, in our boy's case, this seems for the time to be happening, though the night cough and expectoration is like the commencement of bronchiectasis.

He does not for the moment, whatever he may do presently, afford us illustration of the further surgery of these cases. We will now, therefore, study their surgical treatment without reference to him.

For the purposes of the surgeon bronchiectasis may be diagnosed by the physical auscultatory signs of a cavity which the medical wards will have familiarized you with. Then by the history that after an interval from the original mishap of "swallowing" the foreign body, the patient began to have a paroxysmal cough, varying much with the position assumed, but more likely to come on on lying down, and that the expectoration, at first muco-purulent, rapidly became more discoloured and foul, even putrid, and accompanying these were wasting and feverish symptoms. The explanation of all this is found in the fact that, in such a cavity as we are speaking of, the opening into it is not at the most depending part, but nearer the top, hence the collection of putrid material which may not come out and cause the cough, until some special position is assumed.

You may remember that a very similar train of symptoms, excepting the cough, accompanies purulent inflammation of another and natural cavity in connection with the respiratory passages, viz., the antrum of Highmore.

The important point for the surgeon is to discover if the cavity is a single, more or less egg-shaped one, or one of many—a multiple sacculated condition, which I have told you may be suspected in consequence of fibroid change in the lung. If this state of lung is present and the physical signs of cavity fairly extensive, a condition not lending itself to surgery may be suspected. Where, however, the physical signs are distinctly localized and limited, then the single cavity may be diagnosed, and the possibilities of surgery may be considered.

The precise localization of the cavity is difficult; you must, as I have said, first apply the means that are at the physicians usual disposal. Then, if the foreign body happen to be metallic, the X-rays will help; whilst the crucial surgical test (and without it surgical interference is rarely justifiable) is that of tapping the cavity with a suitable exploring cannula or needle. These cavities may form quickly after the impaction of a foreign body, in six to eight weeks; but where multiple or sacculated and largely determined by a fibroid change and contraction of the lung they are more chronic. Other things being equal the more quickly forming cavity is the more likely one for the surgeon to tackle.

And given that the conditions local and general call for surgery, what are the steps we should take?

It is here worth while, parenthetically, to contrast the pleura with the peritoneum from the clinical point of view. Why is it we have not advanced in the surgery of the chest as we have in that of the belly? It is not due to the mere question of septicism; for apart from the fact that the abdominal contents lend themselves at every turn to infection of the general serous membrane, it is an observed matter of fact that a purulent state of the pleura can be borne and recovered from, which would be fatal in the case of the peritoneum.

There are, however, two things in relation to the peritoneum which do not obtain in the case of the pleura: they are the portal circulation (the reflex dilatation of which by the influence of a septic peritoneum may drain the systemic circulation to a dangerous extent); and then the great expansion of the sympathetic system, which is greatly influenced by inflammatory states of the peritoneum. Yet, in spite of this

"delicacy" of the belly to interference, we have by asepticism mastered these difficulties, and suddenly advanced in our surgery of it to a phenomenal extent. Again, then, I ask, Why is it not so in the case of the chest?

In the first place contrast the abdominal walls with those of the chest. The former permitting an incision of any extent without (comparatively speaking) any harm to the patient; the latter, at the outside, by the removal of a portion of rib, giving us but a limited working opening of perhaps four square inches. Then the physical conditions, in regard to atmospheric pressure, under which the thoracic viscera are placed, are by a simple incision at once so disorganised as to be almost fatal to the patient; the sudden collapse of one lung bringing about an embarrassment of respiration which it is dangerous and rash to provoke without the gravest reason. Where prior disease of the pleura has existed, the presence of adhesions may be of some assistance to obviate this; but experience shows that they must not be relied upon.

Taking, then, a broad clinical view of the question, we may say that the surgical dangers in abdominal work are the outcome of sepsis, and these we are learning to obviate or combat, but those in operative work on the thoracic contents are mainly physical—questions in pneumatics largely—and these are very difficult to overcome.

In detailing to you the steps of an operation for opening such a cavity in the lung as I have above described as suitable, you will, of yourselves, see where each more or less perfectly overcomes the difficulties I have mentioned.

First.—Localize the cavity with the exploring needle, and having found it, leave it *in situ* as a guide to follow, just as you have seen done in the case of deeply-placed, localized and small empyæmata.

Secondly.—Resect, in the usual way, and without injury to the pleura or intercostal vessels, portions of two ribs. These removed, vessels crossing the line of operation are dealt with *secundum artem*. If now you were to open the pleura as you would if it were an ordinary empyæma, the lung would collapse, your whole object be defeated, and the patient's life be at least jeopardised. Therefore

Thirdly.—With a fully-curved needle deliberately make a circular line of stitches (enclosing as large an area as possible) through the exposed parietal pleura and into the underlying lung, piercing the latter to the depth of a quarter to half an inch to get a good hold. By this means an air-tight space is cut off from the general pleural cavity in which the surgeon may work without fear of air escaping into the pleural cavity and causing collapse. To make assurance doubly sure, a second line of suture inside the first ring has been recommended.

Lastly.—The pleura and attached lung being incised, suitable forceps can be thrust, Hilton fashion, through the over-lying lung into the cavity it is desired to open, using the cannula or grooved needle (which, we assume, is still *in situ*) as a guide.

Whether the foreign body will or will not be reached by the surgeon, or will be expelled by the patient, will depend upon many and obvious circumstances; anyhow, the surgeon can now chemically cleanse the cavity, establish free drainage, and so improve the patient's condition.

There are no special rules for these steps, the surgeon's daily experience must alone stand him in good stead, but he must bear in mind that by position of the patient, as well as by the way in which he uses his lotions, he must, as far as possible, prevent any fluid he may employ entering the general "bronchial tree," and thus do more harm than good with his antiseptics.

As a matter of pure surgical manipulation, the opening of any lung cavity is not an operation of great difficulty, but the conditions of formation of *vomicæ* generally, preclude the likelihood of any good to the patient by so doing; in the one case, however, we have been studying, that of an impacted foreign substance, the maximum of good may be anticipated, and thoroughly warrants the patient in running the concomitant risks.

WE would remind our readers that the annual subscription to the Clubs' Union for the GAZETTE and REPORTS falls due on the first of next month. Cheques and postal orders should be made payable to Mr. S. H. Croucher, at the Medical School Office.

The Theatricals.

THE theatrical performance in the Court Room given by the Resident Staff, must rank as one of the most successful entertainments of this eventful Christmas time. It is a season of the year when great demands are made on each and all, and it would have been small wonder if the general hurry and bustle had robbed the performance of some of its excellence. But Guy's men are notorious for their powers of concentration, and these aiding and abetting an admirable management, made them stand forth as usual "masters of the event."

The first item of the triple bill was a duologue adapted from Anthony Hope's "Philosopher in the Apple Orchard," which afforded Miss Violet Darrell and Mr. Woodward ample scope for an excellent piece of acting. Miss Darrell was charming as Miss May, and she made us all feel the foolishness of Mr. Jerningham's wisdom. The part of that "hide-bound pedant" was admirably rendered by Mr. Woodward, who, in spite of the fact that "make up" had not sufficiently damaged his pink and white youth, nevertheless gave such an impression of imperviousness, that a charming lady in high position on the nursing staff declared she would like to smack him.

[The gentle reader will doubtless have noticed that the ejaculations of the fair sex at theatrical performances may be divided into two classes, inasmuch as they represent true or false emotions. For instance, "isn't she sweet" belongs to the spurious class, because there is an ulterior motive, the male companion being supposed to combat the statement, but a desire to *smack* an actor, is a sure sign that he is playing with conviction.]

In the "Ghost of Jerry Bundler" a flight into the realms of tragedy was essayed and achieved. Nothing could have been more natural than the conversation of the various worthies around the fire preparatory to retiring for the night. Simplicity, that most difficult of all effects, was preserved (note the flavour of subtle decadence in this epigram—it is almost worthy of the Yellow Book). There was no superabundance of costume and "make up," the stumbling block of many an amateur. As the evening wore on and the general feeling of eeriness increased, with the ghastly details so ruthlessly enumerated by Penfold (Mr. Pearson), there were shiftings in chairs inimitably executed, which betrayed that natural desire to avoid all spectral fingers tickling the neck. The anxiety of Beldon (Mr. Robson) was especially ludicrous, though one could not help thinking that the enormity perpetrated by this gentleman in the way of a waistcoat would be enough to scare away the most malevolent spectre. The gaiters upon the legs of Dr. Leek (Mr. Atkins), together with the faultless puffs of smoke emitted from his medical mouth, caused the greatest admiration among the audience, who could not imagine why, with such appurtenances this gentleman did not walk up and down immediately in front of the footlights with his usual careless and easy grace. We believe that "perfect duck" was the actual epithet applied to this actor, and it really was wonderfully appropriate, was it not?

Mr. Woodward's rendering of Hirst was excellent, as one might have expected. He had a part which suited him entirely; in fact, the chief feature of this piece was the almost ludicrous resemblance between the characters of those portraying and the characters portrayed.

Some generous friend of the gentleman who played Malcolm so admirably, remarked that in places this gentleman had no need to act his part. In fact when he declared that he was "going to the bar to hunt for the spirit," he was merely repeating a daily formula. (We do not believe this is really so, but we repeat it for what it may be worth). To return to our muttons: Mr. Woodward succeeded in thrilling his audience; when he burst into the room declaring that he had just seen the ghost, we were seized with a feeling of apprehension, and this increased during the interval occupied by Malcolm, Beldon, and the waiter George (Mr. Brydone) in hunting the house for the apparition. On their return, the way in which the moonlight streamed into the room made us absolutely certain that "something was going to happen," and we were right in our surmise, for Hirst, impersonating the ghost, entered "left" and was almost immediately shot through the heart by Dr. Leek. The hysterical sobbing of Somers, admirably played by Mr. Gray, brought down the curtain—or rather the curtain fell while Somers was sobbing. The management and the performers are to be most heartily congratulated on "The Ghost of Jerry Bundler." It was an entire success from start to finish.

Of that third and last effort, "The Area Belle," it is almost impossible to write. That it was a roaring success, was the verdict of all who saw it.

Mr. BRYDONE'S matronly Penelope was full of verve—she was also (like Mr. Tree when playing Hamlet) funny without being vulgar. The curtain rose to her flute-like voice declaring that *she* "Would like to be a dysey if she might be a flower"—and fell immediately after an unfortunate accident to her hair ("What a falling off was there.").

Mr ROBSON'S Mrs. Croaker provoked much merriment, he strongly reminded us of someone on the premises. Also, as a sneezer, Mr. Robson is great.

Mr. ODGERS as Walker Chalks, was a milkman to the life, only more so. His dialect was admirably sustained, and we wished there could have been more of him.

Mr. BRAILEY as "Tosser of the Grenadiers" was as might be expected, military to the core. His performance was so life-like as to make us doubt the entire correctness of his military experience.

Mr. WOODWARD as "Pitcher of the Police" was of course the multum in parvo, the sine quâ non, etc. etc. He was the life and soul of the farce. We wish that all policemen were like Mr. Woodward's Pitcher—they would lend the touch of comedy to our otherwise serious dealings with the Force, and they would tremendously enhance the interest of our highways and byeways (and ditches). At times he was delightfully inarticulate, but then one

cannot speak with a whole leg of mutton, or a whole piece of pickle, or a whole glass of beer in one's mouth. We took him for granted later, and his expressive face spoke volumes. Mr. Woodward must be terribly difficult to act with when he is full steam ahead.

PROGRAMME.

OVERTURE.

"A COMEDY OF COURTSHIP."

An episode adapted from Anthony Hope's tale, "The Philosopher in the Apple Orchard."

Mr. Jerningham - - - - - - - H. M. M. Woodward.
Miss May - - - - - - - - - - Miss Violet Darrell.

1. Pianoforte Solo - - - - - - - - G. A. Ticehurst.
2. Violin Solo - - - - - - - - - - F. M. Longson.
3. Song - - - - - - - - - - - - - R. Felton.

"THE GHOST OF JERRY BUNDLER."

By W. W. JACOBS and CHARLES ROCK.

(By special permission of the Authors).

Penfold - - - - - - - - - - - - - - A. Pearson.
Malcolm - - - - - - - - - - - - K. V. Trubshaw.
Hirst - - - - - - - - - - - - - H. M. M. Woodward.
Somers - - - - - - - - - - - - - A. C. H. Gray.
Dr. Leek - - - - - - - - - - - - - J. Atkins.
Beldon - - - - - - - - - - - - - W. M. Robson.
George (a Waiter) - - - - - - - - J. M. Brydone.

Scene: A COUNTRY INN.

1. Pianoforte Solo - - - - - - - - G. A. Ticehurst.
2. Song - - - - - - - - - - - - - Nurse Maddison.
3. Violin Solo - - - - - - - - - - F. M. Longson.
4. Song - - - - - - - - - - - - - H. D. Wyatt.

"THE AREA BELLE."

A Farce in One Act.

Pitcher (in the Police) - - - - H. M. M. Woodward.
Tosser (in the Grenadiers) - - - - - W. H. Brailey.
Walker Chalks (a Milkman) - - - - P. N. B. Odgers.
Mrs. Croaker (The "Missus") - - - - W. M. Robson.
Penelope (The Area Belle) - - - - - J. M. Brydone.

Scene: MRS. CROAKER'S KITCHEN.

"God Save the King."

A CRITIQUE.

Before attempting a criticism of the performances of the 26th and 27th of December, I should like to say, as it is my intention to speak without fear or favour, how very much the Nursing Staff appreciated the successful efforts of the Residents to give them a Christmas treat. Neither the pains expended, the work involved, or the expenses incurred were lost on the audience, and to borrow Miss May's adjective, the performances were enjoyed "tremendously."

The dramatic portions were evidently chosen to suit all tastes. The elusive and sentimental, the weird and tragic, and the farcical.

The first great disappointment was evinced, that the Philosopher was too obtuse and too cold-blooded to fall a prey to Miss May's fascinations, that, however, is a matter with which to pick a bone with the author.

I do not know whether Mr. Woodward will be always available, but his acting met with unqualified approval. As for Miss May, well, hers was the kind of part to induce every girl to say to herself, "It is all so easy and natural I could do that to perfection," whereby we suppose Miss Darrell showed herself to be a splendid actress.

The first part of the second piece was rather lost on the audience, owing to the elderly gentleman not speaking up quite as well as he should have done, and some others dropping their voices too much at the end of their lines, which, however, was the only trace of the amateur to be seen in this most excellently acted little piece. It found most favour in the front seats, though the young blood was frozen, and each particular hair did stand on end with a cap on top in a truly Shakesperian manner, and it was a matter of general grief that it should end tragically, though it was undoubtedly far more dramatic.

The piece of the evening was "The Area Belle;" without a doubt it appealed to the gallery; nothing unkind is intended by that, but it is not easy to understand why a piece that is not artistic, dramatic, or witty, should have found so much favour. We believe it was written at a period when the *lever de rideau* was a matter of no account, when the curtain raiser was intended only to usher people into their seats; be that as it may, it certainly scored more heavily than any other part of the performance, the management of the petticoats, the voracious amount of cold mutton consumed in such a self sacrificing manner by the actors, the jokes alluding to "St. Critical" and "ghastly ulcers" brought down the house. Mrs. Croaker and the "Belle" were splendidly made up, and the manly voice of the latter came as quite a surprise. The songs and music were perhaps the least successful part of the evening, principally owing to the curtain at the back carrying off the sound.

Nurse Maddison's sweet voice was not at all heard to advantage, nervousness and a poor accompaniment were factors which counted against her. The 'cello was not well heard for the same reason. But none of these little matters were of enough moment to mar an evening of perfect enjoyment for which the performers are all most cordially thanked by those who experienced the pleasure of listening to them.

Notices.

DEMONSTRATOR OF PHYSIOLOGY.

There is a vacancy for the above. Duties to commence at once. Applications should be sent to the Treasurer, Superintendent's Office, not later than Friday, January 9th. Particulars of the appointment may be obtained of the DEAN, Medical School Office.

Obituary.

Mr. Henry Collier.

We regret to announce the death, after an illness of some duration, of Mr. HENRY COLLIER, who, until the autumn of 1901 had filled for many years the office of head dispenser at the hospital. It will be recalled that Mr. Collier had not enjoyed good health for some little time before he left the hospital, but it was hoped that the well-earned rest which the resignation of his post would bring him, might result in his enjoyment of some years of comfortable leisure. This, however, was not to be, and after a good deal of suffering from his old ailment of heart trouble, he passed away on December 8th, and was buried in the Lee cemetery on his fifty-ninth birthday.

Many generations of Guy's men since his appointment in 1874, will bear in mind the kindly sympathy and courteous attention that was always shown them by our late dispenser, who, never chary of his time or trouble, would always be found willing to give his help or assistance to anyone about the place who required his aid.

Upon his resignation, though not of the age limit, the Governors granted him his full pension as a mark of their recognition of his excellent service, while his numerous friends readily subscribed towards presenting him with a handsome service of plate.

He will always be remembered as an upright servant of the institution, and we are sure we may offer on behalf of our readers our sincere sympathy to his widow and family in their bereavement.

Note on the Supinator Longus as a Gun Muscle.

BY R. CLEMENT LUCAS.

WHEN lecturing on Anatomy, and teaching the action of the supinator longus muscle as a flexor of the forearm, I was accustomed to ask the members of the class to first pronate strongly their forearms and then to feel the lax state of the biceps during flexion in this position, and afterwards to compare the firm contracting supinator longus undertaking the work of the biceps during pronation.

It happened when shooting on the 1st of September this year that I met with an accident which broke my gun and caused some damage to myself. Recovering before my gun was out of hospital, I began to shoot with a very heavy old gun that I had discarded some fifteen years ago for a more modern and lighter weapon. After some days of exercise with this gun I was surprised, one morning in my bath, to see how the supinator longus of my right arm had become hypertrophied and stood out above the other muscles of the forearm, the pronated position of the trigger hand having contributed to this result. The left supinator showed much less distinctly, as the barrel hand is only slightly pronated and the biceps and brachialis anticus continue to do a large part of the work.

The right supinator longus must be regarded, then, largely as a shooting man's muscle, for it does the main part of the work in raising the gun to the shoulder before firing; and a badly developed muscle after a fortnight's sport in shooting would be rather an indication of indifferent sport. How is your supinator longus, Mr. Editor?

Pass List.

University of Oxford, Michaelmas Term, 1902.

SECOND EXAMINATION FOR THE DEGREE OF BACHELOR OF MEDICINE.

PATHOLOGY.—J. M. Bickerton, O. W. Richards, W. E. Robinson.

MEDICINE, SURGERY, MIDWIFERY, FORENSIC MEDICINE, AND PUBLIC HEALTH.—W. L. M. Day, O. W. Richards.

Papers by Guy's Men.

Unrecognised Influenza. By the late J. W. Washbourn, C.M.G., M.D., and J. W. H. Eyre, M.D.—*British Medical Journal.*

Passim.

THE HOSPITAL CHRISTMAS.

THE Christmas that has just passed will be remembered for two points, the unusual beauty and variety of the nigger costumes and the great success that attended the amateur theatricals organised by the Residents. It is as of yore, the merriest, maddest time of all the glad new year, and it is unique in itself, though at most hospitals and infirmaries there is the same spirit if not the same execution.

THE ward concerts took place as related at length in our columns and varied but little from the usual arrangement, and here we should like to say that in this issue, we are *not* responsible for the tone nor the bias of any criticism, only for their being in good taste, lest we should be accused of partiality.

CHRISTMAS in a hospital to the general public is usually considered as one of the most doleful ways of enjoying that happy season, but we are sure that few, if any, of our unwilling guests have really sighed for their own fireside after the first regrets passed.

IT would need the pen of the *Daily Telegraph* "special" to adequately portray the feelings of admiration, or to depict constant surprises that greet us at every turn.

EVERY year there is ever a suspicious influx of "chronics" into the wards just before Christmas to be in time for the Christmas festivities, and the anxiety of the Borough children to obtain access to the out-patient tea, is most embarrassing.

THE ward concerts are an old institution that are hallowed with tradition, and kept alive by emulation, but we are not sure that as a Christmas custom they are not a little overdone. While we have nothing but the greatest gratitude to those who spend their afternoons in the uncomfortable task of singing songs and "pushing" comicalities in all and every unoccupied ward, still the great set concert, with a large "star" programme of great names whose appearance will *not* take place, and the great influx of outsiders pure and simple, to our mind is getting too much of a good thing, and, we believe, is likely to pass away.

THUS can now be seen in the wards an unofficial concert, with occasional "snap-dragon," unheralded and preserved to the legitimate patients and ward frequenters, the seed from which the present mighty ward concert has grown. The concerts are for the benefit of the students and nursing staff and their friends, and former members of both, and less for the benefit of patients, though their interests are carefully secured. It would, perhaps, be better if the ward concerts another year were more quiet and less open to the world, for we must avow our preference for the simpler manner. And yet, when all has been said, how very successful were some concerts and to what a host of helpers is our charity indebted for ready and talented services. It were invidious to mention names, and we would not say one word against the concerts that may be interpreted as detracting from the value of their services, but we really are beginning to think that if the concerts were more homely and less placarded with high-sounding names, more replete with our own abundant talent among nurses and students, the ward concerts may yet regain their old success.

THE decorations this year showed less originality, but greater success; the lighting was more uniform and less irregular. We may, perhaps, be allowed here to express our sense of the kindness and the endless trouble that has well earned the gratitude of the Residents, with the stage and admirable lighting in the Court Room, of the sisters and wards for the stages and electric lights, and of the students generally for the great trouble taken on their behalf. We are indebted to Mr. Pelling for the stages and the Court Room; Mr Barnes, the engineer, for the electric lighting; and the "Niggers" owe to Mr. Pelling the invention of their motor-car, and to many a sister and nurse invaluable help with their costumes.

THE going off of the old year was as impressive as any modern function can be without being grotesque. It forms a part of that great mental picture the last week at Christmas time of an appointment or a studentship, and it is to many the "parting of the ways." The fast and furious Christmas round culminates after a mirage of dim and beautiful wards, with varied and kaleidoscopic concerts, in a solemn almost religious assembly round the statue of the Founder, and as the torches flare and old Thomas Guy gazes at the thronging Borough crowd through the unusually fast shut iron gates, and the President awaits the hour of midnight, it is in truth a time of awaiting, of suspense. Ave Cæsar imperator morituri te salutamus — strikes the clock and he has passed. It is the pause before the final act, in another second the fire is kindled, the Cathedral clock booms, the bells ring, "Auld Lang Syne" rises tunefully, chestfully, and occasionally heartfully from a ringed mass, and as the flames mount, the President standing beside Thomas Guy with a flaming fire behind him, signifies the dying of the year in a halo of splendour, the waning and passing of his own position, and another Christmas has gone, full of life-long memories, rich in memorials. Then as the dying year expires, the embers crackle and glow, the mad circular dance holds sway till the cheering and chairing of the "Offgoing" and the "Oncoming" completes a scene that one would not wish to miss, a scene as stately in its way as one conducted with the ordered pomp and all the trappings of power.

Le roi est mort, vive le roi.

NEXT night another goes round, another seats himself in your accustomed seat, the shock is distressing, and the feeling most unpleasant, but yet the world goes on as before. "Forward! ye have your niche to fill, see that ye find it indeed."

THE past quarter has been one of well-earned success. The dance was a tremendous success, we believe the must successful ever given, to judge from the guests' remarks and our own experience. The Niggers were the best dressed and the "turns" the most ingenious for many a year, and the modern innovation, the Nurses' entertainment, was a glorious and artistic success. We mention no names, but all the hospital know the names and able managers of the above, to whom we tender our heartiest congratulations.

THE year has gone like many a one before it, and died with the crackle of holly and fun, leaving a sense of weariness, a memory of unusual and festive feast, a sense of virtuous weariness and a pleasant, self-satisfied feeling. As Sir George White said, "Thank God, we have kept the flag flying," and we may truthfully say we have maintained, with other generous assistance, the elaborate and costly week known to us all as Christmas, and yet we feel assured *none* repent the labour and few will stop to count the cost, large though both these have been, but we touch on the latter elsewhere.

THE Hand of the Reaper has been heavy on many at the close of the old year, and the year's tale of loss is not light; indeed, the fatalities at the hospital have exceeded all previous records, we hear. Perhaps the most gloomy episode was the virulent outbreak of sepsis among a few patients, and the loss of two who were little more than students—Patrick Manson and his close friend, M. D. Wood, while the first Resident to die in the College passed away in May in the person of Edwin Stolk. The obituary includes Henry Oldham, the old time popular, polished obstetrician and gynæcologist, who carries us back to the dawn of our most glorious epoch, and who was a contemporary with our most famous and world-renowned sons whose names are so often on our orators' lips.

ON the morrow of the feast the aftermath is generally uninviting, but to those toilers who remain there is the unwelcome winding up and the payment of bills, and the wearisome and troublesome replacing of things removed or lost, and the return to the ordinary strenuous hospital life, and happy he who can get a short holiday from them first.

THE Funds this year were low all round for some unknown reason, and the payments are a

little less easy to meet, and the problem remains to be faced as to how the balance is to be made up, and the various authorities responsible would be glad to receive any contributions towards the deficit. There was a deficit on the dance which was defrayed by the Residents, and there exists a deficit on the Theatrical Entertainment which yet requires to be met, and the business manager (Mr. J. M. Brydone) will be delighted to hear of any pecuniary suggestion.

WE offer our most sincere condolence to Dr. W. Murray Thomas in his terribly sudden and tragic bereavement. He had married and settled in practice for a little over a year, but just before Christmas his wife, who was expecting her confinement shortly, was taken acutely ill with uncontrollable vomiting, and died, in spite of every surgical aid, of intestinal obstruction due to a band. He was a familiar figure at the hospital and most men of the last few years are familiar with his sketches in the GAZETTE, and to him personally, and to his many friends, we offer our most heartfelt sympathy. We have seldom recorded a more sudden or pathetic calamity.

THE Reports are to be obtained at the Library, and though they are no longer produced by a Constituent of the Clubs' Union, still they will be eagerly read and stored. No Guy's man's library is complete without them as a reference book. They may be obtained by Guy's students at 5s., and with the GAZETTE by old Guy's men for 12s. 6d. per annum.

Appointments.

ASSISTANT DEMONSTRATOR OF ANATOMY.

JANUARY—MARCH, 1903. Mr. H. A. Watney.

CIVIL.

POLLARD, C., F.R.C.S. Eng., has been appointed Honorary Surgeon to the Worcester General Infirmary.

ROWLANDS, R. P., F.R.C.S. Eng., has been appointed Assistant Surgeon to the East London Hospital for Children and Dispensary for Women.

WALKER, T. MALCOLM, M.R.C.S., L.R.C.P. Lond.. has been appointed Medical Officer of Health to the Banbury Rural District Council.

Christmas Week.

CHRISTMAS DAY, 1902.

A bright and cheerful morning saw the hospital busily astir at an early hour, for the most exciting time of the year was at hand, and the preparations are arduous.

The day opened with Celebrations of the Holy Communion arranged to suit all who wished to share, and after breakfast a whirl of unwonted movement pervaded the whole place.

Residents and sisters discussed the diets, the smoking, the posture, and this and that detail of the afternoon; nurses and dressers hastened betimes to do the necessary dressings, no stitches were removed, and but few plasters applied. About eleven, the wards were all agog for the Christmas dinner, denuded of the now rapidly darkening nigger.

The sound of the drum furiously beaten by the drum-major (Mr. C. Robson), tastily and airily attired as the prehistoric nigger with his trusty gnarled and knotted club labelled "Ye chloroform." In the park, amid shrieks of laughter, the niggers assembled in groups, unrecognisable, grotesque, delightful, amid the tuning of unmusical instruments. fantasies of freaks, jokes, jests and jollities, and grouped into a wondrous group that might have reminded one of "Reversion to Type"—"a change from a definite coherent homogeneity into an indefinite, incoherent, inchoate heterogeneity, through a series of infinite variations and gradations most amusingly intermingled."

But the most Solemn of all Solemnities—Oh, Best-Beloved—gorgeous in trappings of state, and marked with antient wand, and wearing the pristine cockade was present, and in cold, still, silence the vision of hues and haloes was preserved for ever from destruction by the camera.

From the Colonnade the procession started, and invaded the Eye wards, and the day was well away. Meantime, not unmindful of the present need, each patient, dresser, ward clerk, nurse and probationer, had toiled, tasted, approved and tried again the Christmas dinner, the turkey, the pudding, the crackers, and so forth.

Dinner over, the men proceeded to smoke and recline at ease, while the scurry to arrange, restore, renew and clear—a craze at whose shrine all true nurses and maids must worship—was vehement around them.

The first pause came in Bright, where Sister invited the Most Mighty Solemnity to take coffee, and the Most Military also unbent.

From Bright the strife was renewed, the wheezes resounded, the motor car puffed, and the serious slough of despair! in Out-patients was heroically faced, though the younger and unwary niggers courted destruction by exposing themselves to the youthful Borough wit.

Thence to Clinical, where some attended to clinical beef-juice, or to an alkaline solution of Ethyl Hydroxide, and after a short rest the troupe re-formed in Patience and Samaritan to push each fierce wheeze home, ere they entered into their joyous Christmas feast.

To all those who attended the practices, to Mr. Larkin for his endurance and ready help at the piano, to Mr. Ellis and the corner men for their wheezes, to Mr. Atkins for his energy and organisation, and lastly, to all those whose costumes were so charming, and to all the helpers and organisers our deepest and heartiest thanks are due, and are most gratefully given.

The performances have never been better, and the wheezes went splendidly, the voice of the conductor ever keeping the troupe to their work, and in dazzling succession the day closed with a last visit to Astley Cooper, from whence in wild disorder the troupe scattered to bath, dress and dine.—What ho!—

. . . . . .

Mr. W. M. Robson was elected president. (Cheers.)

. . . . . .

Mr. J. Atkins was elected vice-president. (Cheers.)

. . . . . .

Mr. Robson said never before, he knew it was always said but still it was true, never before had such a noble, manly, upright, popular president reigned as Mr. Pearson.

. . . . . .

The same was said of Mr. Odgers. (Cheers.)

. . . . . .

The same was said of many others. (Cheers.)

. . . . . .

Mr. Ellis and Mr. Edridge replied for the visitors—enuff said.

. . . . . .

The meeting broke up early and quietly.

PROGRAMME.

RUTH AND BARNABAS—1.0 p.m.

Song - - - "The Longshoreman" - Mr. Keates.
Song "His parents hav'nt seen him since" Mr. Ransford.
Song and Chorus "De Ole Banjo" - - Mr. Reeve.

PHILIP—1.15 p.m.

Song - - - - "Nothing New" - - Mr. Robson.
Banjo Trio - - - - Messrs. Cook, Taylor and Ellis.
Song - - - - "Clever Mr. Green" - - Mr. Edridge.
Song - - - "Far away ober dere" - Mr. Bowle.

STEPHEN—1.35 p.m.

Song - - - "Yo ho Little Girls" - Mr. Hicks.
Song - - - "Ma Curly-headed Baby" - Mr. Wyatt.
Song - - - "Zizi Zi Zum Zum" - Mr. Ellis.
Song - - - - "A Military Man" - - Mr. Atkins.

QUEEN VICTORIA—1.55 p.m.

Song - - - "The Rose of our Alley" - Mr. Lacey.
Song - - - "The Miller's Daughter" - Mr. Pallant.
Song and Chorus "Good Night" - - Mr. Reeve.

BRIGHT—2.10 p.m.

Song - - - "Under the Deodar" - Mr. Wyatt.
Song - - "A Perfectly Peaceful Person" Mr. Atkins.
Song - "There's a Home for you with me" Mr. Ellis.

JOB—2.35 p.m.

Song - - - "Uncle Tom Cobleigh" - Mr. Payne.
Banjo Trio - - - - - Messrs. Cook, Taylor and Ellis.
Song - - - - - - "Alcala" - - - - Mr. Felton.

MARY—2.55 p.m.

Song - - - "O, listen to the Band" Mr. Plummer.
Duet - - "The Twins" Messrs. Robson and Atkins.
Recitation - - "Thought Reading" - - Mr. Edridge
Song - - "A Gal with a Rolling Eye" Mr. Ellis

OUT-PATIENTS—3.15 p.m.

Selection - - - - - - - - - - - - - The Band.

JOHN—3.40 p.m.

Song - - - - "Under the Deodar" - - Mr. Wyatt.
Dance - - - - "Highland Fling" - - Mr. Trail.
Song - - - - "The Society Idol" - - Mr. Edridge.

MIRIAM—3.55 p.m.

Song - - - "When I marry Amelia" Mr. Plummer.
Song - - - - "The Vegetarian" - - Mr. Felton.
Song - - "A Perfectly Peaceful Person" Mr. Atkins.

PATIENCE—4.25 p.m.

Song "His parents hav'nt seen him since" Mr. Ransford.
Song - - - "The Rose of our Alley" - Mr. Lacey.
Chorus - - - - Dance and Song - - The Troupe.

CHARITY—4.40 p.m.

Song - - "The Pink Hungarian Band" Mr. Cooper.
Song - - - "Mary was a Housemaid" - Mr. Pallant.
Song - - - "Uncle Tom Cobleigh" - Mr. Payne.

DORCAS—4.55 p.m.

Song - - - "When I marry Amelia" Mr. Plummer.
Song - - - "Far away ober dere" - Mr. Bowle.
Song - - "The Gal with the Rolling Eye" Mr. Ellis.

LUKE—5.10 p.m.

Song - - - - "Phelim's Wake" - - Mr. Keates.
Banjo Trio - - - - Messrs. Cook, Taylor and Ellis.
Song - - - "Yo ho, little Girls" Mr. Hicks.

NAAMAN—5.25 p.m.

Song - - - - - "Honey Ho" - - - Mr. Bowle.
Dance - - - - "Highland Fling" - - - Mr. Trail.
Song - - - - - "Mr. Jackson" - - - Mr. Ellis.

LAZARUS—5.40 p.m.

Song "I can't think of nothing else but you" Mr. Gray.
Recitation - - "Thought Reading" - - Mr. Edridge.
Song - - - - "A Military Man" - - Mr. Atkins.

LYDIA—5.55 p.m.

Song - - - "The Miller's Daughter" - Mr. Pallant,
Banjo Trio - - - - Messrs. Cook, Taylor and Ellis.
Song - - "The Pink Hungarian Band" Mr. Cooper.

MARTHA—6.10 p.m.

Song - - "Sunny, Sunny Sunflower" - Mr. Gray.
Song - - - - "Yo ho, little Girls" - - Mr. Hicks.
Song and Chorus "De Ole Banjo" - - Mr. Reeve.

CORNELIUS—6.25 p.m.

Song - - - - - - "Alcala" - - - - Mr. Felton.
Stump Speech - - - - - - - - - - Mr. Edridge.
Song - - - - "Zizi Zi Zum Zum" - - Mr. Ellis.

ASTLEY COOPER—6.40 p.m.

Song - - - "O, listen to the Band" Mr. Plummer.
Song - - - "Under the Deodar" - - Mr. Wyatt.
Song - - - "Uncle Tom Cobleigh" - Mr. Payne.
Song - - "The Leader of Company B" Mr. Atkins.
Song - - - - - "Good Night" - - - Mr. Reeve.

"AULD LANG SYNE."

THE MEDICAL WARDS CONCERT.

This concert was held on Tuesday, December 30th, 4.30–7 p.m., as last year in the Out-patient Department, and represented Mary, Philip, Stephen, and Clinical

wards. The work beforehand was very heavy as Out-patients were being seen in the concert hall until just on 4 o'clock. At 4.30, however, the whole of the rooms looked as if many weary hours had been spent in the arrangement. The first or medical division was set out for tea—and the artistic array of small tables and ferns on soft carpets reminded one of Bond Street rather than the Borough. The platform at the far end of the surgical division was tastefully decorated with the "Royal Standard" and standard lamps, etc. The patients, about eighty in number, who had the front of the hall and easy chairs where possible, all enjoyed the performance immensely.

Of the performers, Madame Emily Frances, Mrs. Rickitt, Miss McBride and Miss Ivy Kemsley sang; Miss Beatrice Groves recited. Mr. Scharton, Mr. Strugnell, Mr. George Stubbs also sang. Mr. Valentine Hill gave humorous recitations, and Mr. Wm. Raymond did chapeaugraphy and conjuring. Mr. Barnes accompanied on the piano kindly lent by Erard. Mr. J. Atkins acted as chairman.

It is quite impossible to enter into detail as regards each individual performance without taking up too much valuable space. Our appreciation of the kindness of all those who came down to Guy's to help, is beyond the scope of the printer. The concert was excellent, often humorous, and always displayed the high talent which we were so fortunate to procure in our artistes. One of the most striking features was the tea, which was all that the heart could desire, and for this as for many other comforts we are indebted to sisters, whose help made the concert the success it undoubtedly was.

QUEEN VICTORIA CONCERT.

Monday, 29th December, 1902. In spite of the fact that at the same time at which this concert was held three other concerts were going on, the ward was filled to overflowing, which speaks for itself as to the excellence of the artistes. There was a slight disturbance in the proceedings caused by Chivers who was after four young Borough boys, who (evidently having seen the programme) had squeezed themselves under the Out-patients and concealed themselves in the ward, but perforce beat a hasty retreat. The programme was opened by a duet by the Misses Roper. Miss F. N. Allcock sang "When Cecilia Sings" and "Violets" very sweetly. Miss L. Park rendered the "City of Rest" with feeling. Dr. John Tyler, of Middlesex Hospital, sang "Mary" and "Evening Song" with pathos. Miss Phoebe Hurst charmed us with her delicate touch on the violin. Mr. Walter George sang a laughing song in which the audience could not help themselves joining in. Mr. Ellis sang a song with a sneeze in his characteristic manner. After a short interval Miss Rosalie Crawter's Orchestra played some excellent selections which were greatly appreciated, especially those out of the "Country Girl." Mrs. Shrewsbury sang pleasingly. Mr. Charles King recited, and some of his experiences of the Arctic Regions near Margate were very amusing, and he is also a good ventriloquist. The music was brought to a close with a galop, "Snowflakes," rendered by the orchestra. We are greatly indebted for the success for the zealous and untiring way the orchestra worked, and to Miss Crawter for bringing them to sing at so much trouble to herself.

JOB CONCERT.

Job presented an almost unique appearance with its tasteful and beautiful decoration with flags, which representing every variety and shade of colour, and every nation known to the world, equally attracted and pleased the eye. We congratulate Sister, the originator, on so cleverly working out the plan peculiarly applicable to a ward covering such a very large area, and requiring such a quantity of material to produce any effect. The hall in between the two divisions of the ward requires especial mention, as we can imagine no arrangement more attractive or effective as that produced by the mixture of every coloured flags, with the simple natural beauty of the holly and other evergreens.

The concert proved a great success from beginning to end. It started well up to time, it was crowded with about an equal proportion of patients and other visitors, and there was no delay in between the various items on the programme. Mr. Barnes gave two pianoforte solos with perfect execution and delicate touch, Miss Coles, Miss Lacey, Miss Darrell, Miss Grosmith, Miss Molly Phillips, Miss Ethel Ledger and Mr. Felton sang. Mr. Black played the bassoon. Mr. Brodie pleased everybody with his comic songs, whilst Mr. Will Aris mystified and amused with his clever conjuring. Sister worked untiringly, and can be sincerely congratulated upon the great success her concert proved to be.

LUKE CONCERT.

The Luke concert this year was quite up to other Luke Concerts, and plenty of professional people came down. Miss Madge Vincent came from the Gaiety and gave us two songs, "When I was a child of Three" and "The Miller's Daughter," each song being encored. The violin solos were again this year beautifully rendered by Miss Ivy Angove, who received two well-deserved encores. Mr. Franckiss and Mr. Blanchest sang separately and together humorous songs. Mr. Avon's musical sketches and recitations were well received, the audience always claiming another hearing. Some very good "Limericks" were introduced into the musical sketches.

CHARITY CONCERT.

The Charity Ward Concert this year was enjoyed by everybody. Miss Everill Spain, Mrs. Weir Rickett and Mrs. Halsbery dressed up as Japanese ladies, and scored a great success singing Sullivan songs. Mr. Gordon Walker's comic songs were much appreciated. Three professional gentlemen who were expected to perform were not able to do so. There were several good violins present. The success of the evening was a rendering by

Miss Everill Spain and Mr. Spain of the Quarrelling song from the "Country Girl." This had to be repeated, and Mr. Ransford is to be congratulated on a r successful concert.

CORNELIUS CONCERT.

Owing to the break-down on the Tube the contributors to this concert were late and for the first forty minutes we had to rely almost exclusively on local talent Mr. Ransford played two pieces on the pianola with much feeling and action. Then Mr. Ellis told us how to use "four quarts of water," and Mr. Edridge recited "Common Objects of the Sea Shore." Miss Agnes Tandy's contralto voice was very much liked and an encore was given. Miss Coles sang very beautiful soprano. The violin solos were splendidly rendered by a young lady who has been here before, Miss Ivy Angove, and she played four pieces before the audience would be satisfied. The feature of the evening was the Guildhall Glee Quartette. Their renderings of songs, comic and serious, were very beautiful, and they were not allowed to escape before singing four times. We had a beautiful tenor in Mr. Edmund Sherras, of "Belle of New York" fame. After singing all his own songs he had to send to the Charities' room for more. Nurse Pettit very kindly played the piano until our accompanist, who was hung up on the Tube, could get down.

There was another Concert on Wednesday, in Cornelius, when Dr. Lulham brought over an Amateur Orchestral Society, who were assisted by Mr. Curling Bates and Mr. Wyatt. Mr. Wyatt's voice was in splendid condition, and he has probably never sang better than on this occasion. The concert, which was a short one, went off very well, the ladies' voices especially claiming attention.

DORCAS CONCERT.

This was held on Tuesday evening, December 30th. The ward looked very pretty, the decorations being among the most successful in the hospital. The programme was one of the longest on record—the concert lasted three and a half hours—while the excellence of the members and the enthusiasm of their reception was sustained to the end. Of the performers, thanks are particularly due to Miss Florence Shee, Miss Elsa Savill, Miss Lilian Spenser, Miss Winifred Love, and Miss Darell. Miss Shee was, we think, at her best in "There's a Land," while Miss Savill's rendering of "Under the Deodar," was especially pleasing. One of the features of this concert, as at many others this Christmas were the West Country Songs of Mr. Payne. None were so much appreciated by the patients. We are also much indebted to Miss Edith Nutter and Miss Ivy Kensly, and to Messrs. Bowle, Black, Edridge, Ellis, Hall, Felton, Wyatt and Ticehurst for their kind help, without which the concert could not have been the success it was. And lastly we must mention the hornpipe danced by Miss Jose Smith. Albeit that towards the end the audience dwindled, we venture to think that no concert was more appreciated by those for whom it was intended—the patients.

ASTLEY COOPER CONCERT.

On the last day of the old year, the Christmas festivities reached their finality in Astley Cooper in one great blaze of triumph. Naturally, the proportions of the ward are an important factor in the success of any concert given therein, for the seating accommodation is great enough to allow a sensation of comfort to the audience. Even the most artistic musical item loses half its charm when the auditor is struggling with dozens of others for a tiny mouthful of oxygen. In Astley Cooper the chairs were well distributed and well filled, so that the residual mob at the doors was reduced to a minimum. And then the next item of success—the programme—was excellent. Miss Crawter was responsible for a large share of the programme, and must be most heartily congratulated on her achievements. I have listened to many bands, amateur, professional and Sousa, but few have given me greater pleasure than Miss Crawter's Ladies' Orchestra. It was somewhat of a novelty to see the fair, or fairer, sex playing the essentially manly wind instruments, and not a little piquing, since they blew so well. Miss Lily Honig played the flute *comme une ange*, and trifled with the piccolo in admirable style. As it should be in a well-balanced orchestra, it was impossible to pick out any individual for especial mention. But not so with regard to the items, for in the "Merrie England" selection the orchestra reached a high artistic level, and was deservedly encored by the audience. The programme, which I do not append, was in no sense strictly followed. There were the usual absentees, as one expects in influenza time, and local talent was introduced in compensation. Here, in justice to the local talent, must I say that the concert in no wise suffered by the change. Mr. Payne purred his Devonshire songs to the delight of all, and was only allowed to retire after singing five songs. Mr. Atkins wanted to be a military man as only Mr. Atkins can want, and gave as an encore a study of a perfectly peaceful nigger with immense success. Mr. J. E. Collins, the military poet-actor-dramatic-literary-medical student, produced, staged, managed and acted all by himself a sunny melodrama with numerous characters and a tragic ending. He afterwards conducted a quartette, in which he took all the parts himself. One patient with a scalp wound had to get a friend to hold his head while he laughed. Then Nurse Horseford, with a pretty and essentially musical contralto voice. More encores of course. Mr. Withers sang well and tastefully, and his really fine tenor voice was heard admirably in the ward. But how can one go on? They were all good. There was not a weak item on the programme. Mr. Ellis with his soup receipe, Mr. Kay Edridge with Anstie, Guthrie and a bit of Kipling, Miss Amy Porter with her 'cello, Miss Bessie Greenhill with the violin, and the Ogden trio—all good and all appreciated. And the ward itself, was there a prettier

platform than Astley Cooper's? I doubt it. Were there more tasteful decorations? Impossible. Was there a more appreciative audience? [Order, order.—ED.] Never! And Sister, and the nurses, and Mr. Gray, and Mr. Odgers, also the excellent dressers of the three firms, all busily engaged in looking after every one, made the evening one of supreme satisfaction and content to your contributor.

Guy's Hospital Debating Society.

ON Saturday, December 13th, the Debating Society held its third meeting this session. The chair was taken at 8.15 by Dr. Spriggs, and the minutes having been read and confirmed, the evening's proceedings commenced with a brisk attack on the secretaries by Mr. Collins Lewis. This gentleman, rendered unduly truculent by the fumes of a cigar, denounced the "powers that be" for the absence of a bell; he said that such was his own volubility when once he started, that nothing could stop him effectively save a bell ringing very loud and clear. Also, as a member of the committee, he longed, he would even say he pined, for a committee meeting; the fact that he would himself, in all probability, not put in an appearance unless continually reminded for a fortnight previous to the event, made no difference, the chance of being present would supply a long-felt want. In consideration of his condition this point was generously conceded, and he sank back with a sigh of relief.

The chairman then called upon Mr. Griffin to propose, "That in the opinion of this House the savage is happier than the civilised man," and thereupon that evergreen gentleman arose amid rounds of applause.

Mr. GRIFFIN explained to the House that owing to the illness of Mr. Allen, who was otherwise to have proposed the motion, the duty of defending the savage had, at extremely short notice, fallen to his lot. But he was sure that, with the solitary exception of the gentleman so unfortunately invalided he himself was the man most eminently fitted for this task. His sympathies were well known, they were, as the House knew, always misplaced, and he would that evening give vent to an exoteric display which should surpass all previous records. [What this gentleman actually did say, cannot, unfortunately, be accurately recorded, the following are gleanings]. The savage was, in the first place, physically happier than the civilised man. He constantly saw snakes and other animals, but in his case he was able to fight them into the bargain, and this made him hardy. Ceaseless warfare in savage countries had the effect of preventing overcrowding, and whilst he was saved from the curse of prudery by the discarding of all attire, he also incidentally escaped countless ills that civilised flesh is heir to, by the free respiratory exchange resulting from a blissful ignorance of fancy waistcoats. Europe did its best to degrade this "paragon of animals," by the introduction of its pet superstitions, vices, and diseases. [Here the speaker digressed, and dealt briefly with some aspects of the drink traffic. With the glibness of an Exeter Hall expert, he actually told us the exact amount of money spent per annum in Great Britain on "intoxicating beverages," in this instance the figures happened to be £60,000,000.] The savage was certainly mentally happier, as there were no halfpenny papers; it was true that he could see neither *Reynold's* nor *T. P's Weekly*, but still the absence of the *Daily Mail* counterbalanced these losses. Again, there were no churches (a warning gleam here shot from the chairman's eye, and Mr. Griffin, with a superhuman effort, which was against the whole bias of his nature, avoided the thorny subject). There were no labour problems for the savages to solve, there were no people with pasts, all had presents and that sufficed. In short, the cannibal was, par excellence, the happiest, merriest fellow alive, and the House must see it in this light or it would show that the civilised intellect had been warped by its exceeding unhappiness.

Mr. COLLINS LEWIS was called upon to oppose the motion. He said that the appropriateness of the choice of a proposer of the motion had already struck him—but he deplored the extreme savagery of Mr. Griffin. He had not expected him to be quite so abandoned as he had found him. The honourable gentleman had omitted to define happiness; this was an essential for rightful discussion, and he would supply the deficiency. Happiness was the state of mind resulting upon a well-balanced exercise of the faculties. The power to balance was the outcome of civilisation, and the savage was therefore from à priori reasons, debarred from equal happiness, much more than was greater happiness an impossibility. Again, we must distinguish between the happiness of the civilised man and the contentment of the savage. Contentment was merely a passive state not necessarily involving any intellectual appreciation of the good things possessed. Happiness was an active state of the mind partaking almost of the nature of a virtue. The savage moved "in a mysterious way his wonders to"—(but another gleam from the chairman's eye stopped the impending completion, and again saved the theological situation). Well, anyhow the savage was a robber, and the cowardly murderer of any white man who was unlucky enough to fall into his clutches. Can there be happiness in such a state as this. Fear is the savage's constant companion—nature terrifies him, his chief is a "lord of life and death," and he may be called upon at a moment's notice to form the pièce de resistance at a tribal dinner. Here a somewhat curious piece of mental abberation occurred, the speaker referring to Kaid Abderrahaman Ben Abder Sadek, Esq., Governor of Fez, as though he implied that that gentleman was a savage; perhaps he meant subtly to infer that, where there were such "Christian" names there must inevitably be great unhappiness. The speaker then informed a delighted House that Mr. Black would second him, and deal with the ladies of both the parties under discussion.

Mr. WRENCH seconded the proposition. The Samoans had been described by Stevenson as the happiest people on earth. Their existence was, however, scarcely of the strenuous type described by Mr. Griffin. Superstition, the savage's

birthright, was certainly no worse than doubt,—doubt, the outcome of all our knowledge, the great barrier to happiness. Sport was the chief pleasure of the civilised man, not a single Englishman but would go big game shooting if he could afford the time and the money. The savage is free to hunt the livelong day.

MR. K. BLACK arose amid cheers and laughter, and in his characteristic eructating manner, dealt with the ladies. They were dear creatures all of them, without any exceptions. He wept great tears of tenderness as he told us of conquests in far Cathay, and compared these to similar episodes in more cautious Clapham, and in wily Wandsworth. He reached his maximum point of palpitation when he spoke of his old friend the Shah of Persia, who had recently very reluctantly reduced the number of his wives from 1,070 to 60, in imitation of western civilisation. Towards the end of his speech he became almost inarticulate, but still through the rattle, parts of speech were rife;—and he seemed to be appealing for the votes of the House.

Dr. PEMBREY next followed with a perfect torrent of eloquence. He treated the subject from an entirely physiological point of view. Woman was an inferior creature, and was much happier, subject to man. Civilised woman was striving to escape from this subjection, and by attempting to ape her natural over-lord, she tended to lose her physiological significance. The savage on the other hand was still in a state of nature in more ways than one, and his women, unpolluted by civilised ideas, fulfilled their natural destinies, asking for no impossible status. In our struggle for national existence, we were compelled to retain savage characteristics, and in proportion as we lost these, our racial supremacy would be endangered. Sport was the saving clause of modern civilisation—it kept us virile in spite of the ennervating luxury which had destroyed empires before now. We must develop our savage characteristics for all they were worth, and in that way alone would happiness be ensured. Throughout this interesting speech the learned doctor stood in a characteristic attitude, singling out previous speakers with a tobacco pipe.

Mr. WEBBER denied that savages were happy. Kaffir women were miserably illtreated, and were compelled to do hard labour in the fields, at times when every law of physiology, to say nothing of ordinary mental consideration, pointed to rest as a primary necessity. Again, fancy having nothing on your thorax.

The Rev. LE FANU next arose and attacked the last speaker but one. Why did not Dr. Pembrey practice what he preached; it made one doubt his sincerity. Let him "paint his face and tire his hair," and divesting himself of wearing apparel, leave for Timbuctoo, and his idea would be respected (at any rate by those he left behind him). As it was they savoured too much of H. G. Wells, who was, in the reverend gentleman's opinion, anathema maranatha. Civilisation, while offering greater extremes of happiness and misery, at least gave far greater opportunities for the former.

Mr. WATNEY said that the intellectual doubt of modern civilisation was not necessarily unhappy; certainly it was rather an advantage to know your limitations. The savage, on the other hand, lived in a state of doubt, that was positively terrifying. Increase of knowledge, too, must inevitably tend towards happiness, but the miserable ammatism of a previous speaker spelled mental and moral degeneration.

Mr. ROBINSON objected to the honourable opposer's definition of happiness; it was a much more negative state, rather one of "No fears and no wants." He spoke of the dawn of religion in savage countries as an era of superstitious terror, producing a state of mind foreign to all civilised ideas of religion. At this point an injudicious reference to a certain theological locality, which is not usually mentioned in the best houses,* brought an interesting speech to an untimely close.

Mr. BOLUS said that although he also was a celebrated physiologist, he did not happen to be a married man. In phraseology worthy of a "lake poet," he spoke of the mise en scène of savage life, of the natural beauties that surrounded the artless aboriginee such as "Lapping water," and "Twittering birds with painted plumage gay," and as an antithesis you had amid the purliens of civilization the "little red brick houses all in a row," and "the motor car horn."

Mr. BRYDONE interpreting the classic reference to the "bye-play of ovum bearing organisms," as meaning the "struggle for existence," "the missus and the kids," spoke of the nobleness of this pursuit as opposed to the irresponsible peripatetics of the cunning cannibal. He declared that the real savage had not yet been mentioned.

Mr. WATTS spoke with that bluntness which characterises all those who are engaged in labours such as his. His remarks (for fear we bring the blush of shame to the cheek of modesty) we forbear to record.

Mr. SPRIGGS gave a short dissertation on very vulgar fractions.

Mr. MYOTT brought in a wheeze about a balance.

Mr. PALMER, suddenly waking up in front of the bar, declared that ancient Britons had nothing whatever to do with it, but he defied any man, especially a modern-day savage, to say Caractacus slowly and distinctly.

Mr. COLLINS LEWIS, in replying, was, as he himself described it, "light, brief, happy and to the point." Mr. Griffin would be perfectly happy, no doubt, sitting on a pumpkin; personally he was more ambitious. His cigar, or what there was left of it, had, it was true, gone out; but if Mr. Griffin would like it, he bore him no malice, but he must on no account light it till he got outside. Dr. Pembrey was evidently henpecked, but he begged him for the sake of the race, to go and prosper—statistics, who knows, might have improved by the time the next debate came on. (At this point, the discourse was drowned by some hirelings, who opened one of the windows and made rude remarks at the honourable gentleman's expense. It was evident that they were in

* Hell.

the pay of the honourable proposer, and it is rumoured that they were members of his club).

Mr. GRIFFIN, in replying, said, he also would be brief. (Cheers). Dr. Pembrey had really exhausted the subject. He would not discuss Indian politics at that late hour—(renewed cheers)—but he would back himself against any man on a discussion of national morality or otherwise. He was certain that he had the sympathy of the House, and there was no need for him to speak further.

On a division 16 voted for the motion.
26 voted against the motion.
Several not voting.

The motion was therefore lost by a majority of 10.

A vote of thanks to Dr. Spriggs closed the meeting.

Presentation to an old Guy's man at Marden.

Presentation to Dr. W. HARLAND PEAKE.

In the unavoidable absence of the Vicar (who kindly lent his schoolroom), Mr. Crowhurst was asked to present a testimonial to Dr. Peake last Monday morning. He mentioned that the poorer patients had taken a great interest in the testimonial and were delighted to give their mite towards it. He asked Dr. Peake to accept a weighing and measuring chair, with suitable inscription, for his consulting room; four cases of silver plated surgical instruments, and several other appliances, as well as a framed list of the names of about 270 subscribers, with the following inscription in the centre: "The accompanying testimonial is presented to Dr. W. Harland Peake, as a token of our esteem and gratitude for his kind and skilful treatment during his practice in Marden." Dr. Peake in reply said it was extremely difficult to express what he felt upon such an occasion, but he thanked the contributors very much for such a proof of their kindness and affection. Dr. Peake has removed to West Hampstead.—*Kent Messenger*.

Reviews.

The price of books submitted for review should in every case be stated.

A Manual of Medical Treatment, or Clinical Therapeutics. By I. Burney Yeo, M.D., F.R.C.P. (Published by Cassell & Co.) Two vols. Price, 21s. net.

It has been said that the theory of medicine is all that the student has impressed upon him before he receives his diploma, and to a great extent this is a true criticism.

To those who have not advanced beyond the stage of writing down prescriptions on the spare pages of the Pharmacopœia this latest edition of a well known and popular work with its copious list of alternative and additional prescriptions will certainly appeal, and it is to the latter that the majority of readers will turn in search of the inspiring draught that will satisfy their most exacting patient.

To the student of treatment from the broader standpoint, it will be apparent that there is not enough about the indications of the various treatments, but rather too much of an agreeable recitative of the various tenets and occasionally "fads" of eminent men. To us it seems that if the book fails, which we do not admit at all, it is that the personality of the author is veiled, and that dogmatism is almost altogether absent. The reader of the works of an eminent authority has the right to see the author's theory and practice to be clearly stated, and the reasons for and against, and the alternatives to them, and that the work shall be more the author's methods with others, than the careful dispassionate symposium of discordant authorities that are becoming so common. We prefer the "dogmatism" of the individual to the "system" of the many.

Thus, it is hard to extract the author's real opinion on the vexed question of appendicitis, the indications for the various alternatives are not clearly stated nor explained, so that any treatment would seem to receive some support from the writer, which is certainly not the case, and in many ways this particular article will not strike the older students as being a good representation of what they see.

The article on Rectal Feeding contains much that varies from our usual practice, and we think the instrument poorly figured, while we would emphasise that slowness in administration is always a most useful practice and quite an essential in difficult cases.

A minor criticism would be that wherever sterilisation of any instrument, such as a trocar or needle, is required, cleaning first and *boiling* is the only proper recommendation. Every house, rich or poor, contains a kettle and matter for fire; only the small proportion will produce spirit lamps, antiseptics, etc.; it is a minor point, but one of vast importance to surgeons or students, the necessity of boiling *everything* that can be boiled, and there are but few necessaries that will not.

Under Dysentery we note a kindly reference to the work, quite recent, of the late Dr. Washbourn.

Intussusception we think to be a weak article, and not to be up to date. The treatment by injection of air we had imagined had long ago been abandoned in favour of a fluid, preferably milk, there being hydrostatic reasons as well as the dietetic advantages in favour of a nutrient medium, and we note that the operative treatment is apparently ignored.

But when all possible criticisms have been made—and it is possible always to criticise—and when all imperfections have been noted, there still remains behind, the fact, that as a manual of Clinical Therapeutics it is a splendid work of great value to all who are engaged in what is truly a life-long study, the treatment of the patient, the surroundings, and the disease, the latter

often being his relations. Theory of medicine does the last, and theoretically the second, common sense and such a book as this will be also of great assistance.

The book is one we would strongly recommend as a manual, it is thorough and full of practical ideas, and there is great variety and originality in many of its articles, and the criticisms we have been tempted to make are provoked by the fact that it has been a book in great demand, and, therefore, the fact of its being widespread makes us more anxious to point out what seems to be its shortcomings.

Metropolitan Asylums Board.

INSTRUCTION IN FEVERS

Commencing January, 1903 (except at the Brook Hospital —commencing 2nd February, 1903).

A Course of Instruction (Three Months) in the Diagnosis and Treatment of Fevers will be held at each of the undermentioned Hospitals, on Tuesdays and Fridays (except at the Eastern, North-Eastern, South-Eastern, and Brook Hospitals), at the times stated below.

EASTERN HOSPITAL, The Grove, Homerton, N.E., at 1.30 p.m. E. W. Goodall, M.D., Medical Superintendent.

(N.B.—The Class at this Hospital will be held on Mondays, Thursdays, and Fridays, beginning 8th January.)

NORTH-EASTERN HOSPITAL, St. Ann's Road, Tottenham, N., at 2.15 p.m. H. E. Cuff, M.D., Medical Superintendent.

(N.B.—The Class at this Hospital will be held on Mondays and Thursdays, beginning 8th January).

NORTH-WESTERN HOSPITAL, Lawn Road, Hampstead, N.W., at 2 p.m., beginning 6th January. W. Gayton, M.D., Medical Superintendent.

* WESTERN HOSPITAL, Seagrave Road, Fulham, S.W., at 2 p.m., beginning 6th January. R. M. Bruce, M.R.C.S., Medical Superintendent.

* SOUTH-WESTERN HOSPITAL, Landor Road, Stockwell, S.W., at 2 p.m., beginning 6th January. F. Foord Caiger, M.D., Medical Superintendent.

† FOUNTAIN HOSPITAL, Tooting Grove, Tooting Graveney, S.W., at 2.15 p.m., beginning 13th January. C. E. Matthews, M.D., Medical Superintendent.

† GROVE HOSPITAL, Tooting Grove, Tooting Graveney, S.W., at 2.15 p.m., beginning 13th January. J. E. Beggs, M.D., Medical Superintendent.

SOUTH-EASTERN HOSPITAL, Avonley Road, New Cross, S.E., at 1.30 p.m. (nearest station, Old Kent Road, L. B. & S. C. Railway). F. M. Turner, Medical Superintendent.

(N.B.—The Class at this Hospital will be held on Mondays, Wednesdays, and Fridays, beginning 12th January.)

PARK HOSPITAL, Hither Green, S.E., at 2 p.m., beginning 6th January. R. A. Birdwood, M.D., Medical Superintendent.

BROOK HOSPITAL, Shooters Hill, Woolwich, at 2.30 p.m. J. MacCombie, M.D., Medical Superintendent.

(N.B.—The Class at this Hospital will be held on Mondays and Thursdays, beginning 2nd February.)

* The Classes at these Hospitals are now full.

† Students joining either of these Classes attend the Clinical practice at both Hospitals, but should they attend both Hospitals on the same day, it will be counted as only one attendance for the purposes of the Certificate.

The Next Course will commence in May, 1903.

N.B.—Students desiring to attend a Course of Instruction must, *before* attending at the Hospital, bring between 11 a.m. and 4 p.m. on any week-day (except Saturday), or send by post to—

The Clerk to the Metropolitan Asylums Board,
Embankment, E.C.—

(1) Authority from the Dean of the Medical School.

(2) Fee—£3 3s. for two months' course, or
£4 4s. for three months' course.
Cheques to be made payable to—
"The Metropolitan Asylums Board."
The Student must *definitely* ascertain *before* taking out his course whether he requires a *two* or a *three* months' course. In the event of his taking out a three months' course, the extra £1 1s. will not, under any circumstances, be refunded to him.

(3) Full Name and Address, and name of Medical School.

(N.B.—The name must be *in full*, and must be *distinctly written*.

(4) The Names of two or more of the above Hospitals, arranged in the order in which the Student would prefer to attend, in case the classes at any of the Hospitals should be already full. *At least two names should always be given.*

By Order, T. DUNCOMBE MANN,
November, 1902. Clerk to the Board.

Births.

DAWSON.—On Christmas Day, at Portarlington, College Place, Southampton, the wife of W. J. O. Dawson, L.D.S., R.C.S. Eng., of a son.

POLLARD.—On December 3rd, at 23, Foregate Street, Worcester, the wife of Charles Pollard, F.R.C.S., of a daughter.

THORPE.—On December 22nd, at Cleveland House, Balham High Road, the wife of W. G. Thorpe, M.D., of a son.

Marriage.

PANTING—HEPBURN.—On December 19th, at St. Mary's, Aldridge, Laurence Christopher Panting, M.A. M.D. Oxon., of Truro, to Jane Agnes, younger daughter of the late Archibald Hepburn, Esq., and Mrs. Hepburn, of the Moat House, Aldridge.

ED.—J. M. B.

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Calendar of Coming Events.

Jan., 1903.

Sat. 17.—Messrs. Golding-Bird and Dunn's take-in: Drs., J. F. Rey and A. E. F. Kynaston; Cl., C. R. Howard.
1 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., I., Rosslyn Park, home.
II., Polytechnic, away.
G.H.A.F.C., I., Beckenham, home.
II., Beckenham II., away

Mon. 19.—1.15 p.m., Clinical lecture by Mr. Higgens.

Wed. 21.—1.30 p.m., Clinical lecture by Mr. Jacobson.
G.H.A.F.C., Old Carthusians, home.

Thur. 22.—Messrs. Jacobson and Fripp's take-in; Drs., L. H. Frankenburg and E. Lloyd; Cl., G. Evans.
Inter-Hospital Rugby Cup Match, St. George's v. St. Bart's.

Sat. 24.—1 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., I., London Welsh, home.
III., Ealing "A," away.
G.H.A.F.C., I., Weybridge, away.
II., Woodford Albion, home.

Mon. 26.—1.15 p.m., Clinical lecture by Dr. Perry.

Tues. 27.—Inter-Hospital Rugby Cup Match, Middlesex v. Guy's.

Wed. 28.—1.30 p.m., Clinical lecture by Mr. Jacobson.
G.H.P.P.S., Paper on Arterio-Sclerosis by Mr. C. H. Robertson.
G.H.A.F.C., I., Casuals, home.

Thur. 29.—Messrs. Symonds and Steward's take-in; Drs., G. C. F. Robinson and G. H. Rees; Cl., H. S. Brown.
Inter-Hospital Rugby Cup Match, St. Mary's v. St. Thomas'.

Sat. 31.—1 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., I., R.I.E.C., away.
II., Epsom College, away.
G.H.A.F.C., I., Cheshunt, home.
II., Cheshunt II., away.

Guy's Hospital Gazette,

JANUARY 17, 1903.

1902.

THE opening of the year that has just closed gave no token or warning of the tragic and exciting incidents that were to render it remarkable in men's minds, whether as citizens or as hospital workers.

The opening of 1902 saw the close of the long and rigid rule of court ceremonial mourning, and the nation prepared to celebrate with unwonted luxury and grandeur the enthronement of our former President in the chair of the Scotch Kings in the Abbey of the last English King. Much had been hoped for from this event; the depression in trade, the sorrows of hospital finance, were but two of the least of the hungry phantoms that were to vanish in the good time the coronation festivities were sure to bring. We ourselves had prepared a stirring appeal to the public to finish once and for all our necessary expenditure of renovation and repairs, and our proper accommodation for the nurses and others.

The Mansion House meeting was held on January 15th under the kind superintendence of the Right Hon. the Lord Mayor, Sir Joseph Dimsdale, Bart., who also has joined the distinguished list of Governors of Guy's. The meeting proved a great attraction, and there can be little doubt but that the careful statement of our serious position, unmarred by elaborate rhetoric or eloquent exaggeration came home to those present, but still there is much to be done.

The next event was the acceptance by Mr. W. C. C. Pakes of the post of Bacteriologist to the Transvaal, which involved his resignation of his post as bacteriologist, and severed a close and intensely patriotic connection of many years' standing. He was entertained by his friends and colleagues at dinner.

Dr. T. G. Stevens about the same time was elected Obstetric Tutor to St. Mary's Hospital, and what is our loss we know to be their gain.

About the same time the number of departures and deaths that formed so striking a feature of the middle of the past year began to be remarkable. Following the departure of Mr. Pakes and Dr. Stevens, Dr. A. J. Cleveland vacated the post of Medical Registrarship, and with his wife retired to private practice in Norwich.

Then followed in quick succession the resignation of Mr. Howse, the close of a long and honourable hospital career that had embraced the birth and growth of modern surgery, in which striking development he himself had played, if not the protagonist, at least as far as we were concerned the absolute chief, a fact that ought never to be lost sight of.

This necessitated the retirement of Mr. Symonds from the Throat Out-patient department, where he had enjoyed a clinique second to none, and the accession of Mr. F. J. Steward to the rank and privileges of a Full Assistant Surgeon, with charge of the Throat department, and the aid of the usual house-surgeon and dressers.

Mr. Symonds became Full Surgeon, and succeeded Mr. Howse in Lydia and Job, after a short tour abroad.

Mr. Dunn resigned the post of Warden, which he had held since the resignation of Dr. Perry, and settled himself in Devonshire Place with Dr. W. Sampson Handley, to the great sorrow and surprise of Residents, past and present, by whom he was heartily entertained to dinner before leaving, and presented with a most handsome silver cigarette box with the Hospital arms and suitable inscription.

About this time came the sad news of the sudden death of Patrick Manson, which put an end to a career full of promise, and to a vigorous and striking personality, while the deaths of Nurse Heygate in Clinical, and of Dr. Wordsworth Poole in China, both from enteric, were deeply felt by their numerous friends. Dr. Poole will be remembered as one of the doctors in the Siege of Pekin in the previous year.

In October news also came of the death of M. D. Wood, a close friend of Manson's, from acute septicæmia, which cast a gloom over the College for many days.

Dr. Laidlaw Purves terminated a long and successful career as Aural Surgeon, and was succeeded by Mr. C. H. Fagge.

And now the record for the year, gloomy as it has been so far, becomes uncompromisingly black. The first death in the College took place in May by the demise of Edmund Stott, the junior Charity, the first Resident to die for many years. In June, Miss Cotton, Sister of Queen Victoria, brought face to face with the necessity for operation, preferred, nay insisted, on running by far the greatest risk, lest she might be separated from her work. It was a noble, unselfish end to a most devoted and unobtrusive life of good deeds, and the scene at the memorial service will never leave the memory of those who saw it. Numbers of former patients unknown to any there, drawn by a common, a deep, and alas an abiding sorrow, breaking down in genuine depth of woe, formed a striking testimony that shames the panegyrics of kings, and dwarfs memorials by its grandeur. For such as her far better no memorial tablet, if she has such a universal respect and affection to testify to her merits.

Speaking dispassionately, yet smarting still under the bitter grief of her loss, we may truly say that we shall "ne'er look on her like again," and that she united in herself good birth, the finest breeding, an ideal devotion to her work, an endless capacity for sympathy and a personal affection for her patients that may be equalled but cannot be surpassed.

No nobler life has been given to the poorest of the Guy's poor; her sacrifices of health and strength and her own purse, were free, endless and ungrudging, and her light was hid from the world under a bushel. An ideal Sister in her work, truly holy and noble, honoured, respected and admired both by doctors and nurses.

Her memory for patients' faces, her wonderful and instant recollection of their beds and the wards, the details of the operations and the progress of the case, was truly remarkable, and her keen sense of humour alone would have singled her out as one of no ordinary mould.

Following on so serious a loss in the nursing side came the news of Dr. Washbourn's illness and the rapidly fatal issue, which caused genuine

and general consternation. He was "thorough," honest and unassuming. Great as were his scientific attainments, the most striking feature about him was the enthusiasm and close unswerving friendship that he aroused in those fortunate enough to know him. He had returned from Africa apparently in the best of health and spirits, and the suddenness of his death proved a great shock to the entire Hospital.

The illness and operation on His Most Gracious Majesty the King, Patron and former President of the Hospital, are so notorious that little need be said as to the gloom cast over all the land, but we may say that when the true history of the King's illness comes to be written and published, much that is now obscure will be cleared up, and the part played by Guy's representatives will prove worthy of our past repute. We are glad to see Mr. Fripp, Surgeon-in-Ordinary to the King, was assisting at the operation.

The tale of woe was now apparently complete, for the record brightens, and the next event was the opening of the new nursing home, named by H.R.H. the Princess of Wales the "Henrietta Raphael Nursing Home," in memory of the wife of Mr. Raphael, who gave over £20,000 towards the building, and whose sons have since supplemented their father's gift in memory of their mother.

The ceremony was a great success and no one will grudge the nurses the act of justice by which they received decent quarters during their years of service.

The Biennial Dinner in July, engineered by Dr. Pitt, and presided over by Dr. Galabin, proved a great success and was well attended.

In August the Coronation at last took place, and later the King drove through Southwark, at which function there were innumerable Guy's representatives.

The Nurses' Swimming Bath, the alternate use of which was granted to the students proved a great and welcome boon in the hot summer months; while through the summer, the end of the war which had occurred earlier, brought back many absent faces from the South, heartily welcomed by all they had left behind.

Towards the end of the year two old servants of Guy's, one a veritable link with the past, the well-known Dr. Oldham, who qualified the year the late Queen came to the throne, and the other Mr. Henry Collier, who succeeded to the office, formerly of great importance, of Apothecary, both in retirement from their posts, joined the majority.

The end of the year saw probably the most enjoyable and successful Christmas festivities and the most splendid on record successfully carried through.

The internal arrangements have undergone a most complete transformation. The opening of the New Nurses' Home has altered the whole tone of the place; one effect of collecting the nurses under one roof has been the greater corporate sense, as shown by the desire to debate and to act and so forth, legitimate recreations which can now have their full scope. Among the staff, the alterations were chiefly Mr. Howse retired at the age limit and became Sir Henry Howse, in recognition of his services to surgery, and of his position as President of the Royal College of Surgeons, and Mr. Symonds became entitled to the larger number of beds. The process of renovation has now been so extended that there are but two wards to be done up, and the new Theatres are being pushed on. The Wills' Library is rapidly nearing completion, and the Fives Court has been remodelled.

Mr. Dunn has left the College, and Dr. Eason has become Warden. After great efforts Mrs. Batten has followed her husband, and resigned the catering to Mr. Wade.

Guy's retained the Rugby Cup with a tremendously powerful XV., but the same strength in proportion only led to a ridiculous defeat at cricket.

It may be said to have been a year of gloom and death, while the great achievement of the new Nurses' Home and the Mansion House Scheme alone gave rise to a brighter outlook.

The completion, or substantial completion, of the new Nurses' Home, and the great progress made in the work of renovation, produced a chorus of congratulation for the Governors and Superintendent in which we wish most sincerely to join.

On the Diagnosis of Functional from Organic Paralysis.

CLINICAL LECTURE BY DR. PITT.

November 15th, 1902.

GENTLEMEN,—I propose to-day to bring before you a very interesting case that has been in the wards for some five months, which is almost certainly mainly one of Functional Paralysis, but it is possible there may also be some organic disease. I will, at the same time, take the opportunity of tabulating and drawing your attention to some of the more important points of distinction between functional and organic paralysis.

First of all, it is very important to insist that when we use the term *functional* or *hysterical* paralysis, we are not thereby justified in concluding that there is wilful deception. The patient may do his best and yet without any gross disease be unable to move a limb. Nevertheless, in some cases there is wilful deception, and it is therefore desirable to give up the use of the term *hysterical* in connection with our present subject, for it is so often taken to mean wilful deception; we will simply speak of functional paralysis.

I would next point out that patients with organic disease are, perhaps, more likely than others to have functional troubles, and you must not assume, because a patient has some symptoms which suggest a functional paralysis, that there is no organic disease. Nor must you assume that because the paralysis is transient it is functional. By functional nerve paralysis we mean one in which there will be no gross obvious change detectable post-mortem in the nervous system. Possibly there may be some nutritive, and may be some microscopical change in the nerve elements, but so far as our methods of observation go at present, we are unable to accurately describe such.

Disseminated sclerosis is a disease which creeps on very slowly and about which in the early stage mistakes are constantly made. Such a patient may perhaps consult a doctor for paralysis of an arm, or an ocular paralysis which has come on without any obvious cause, and this may pass off again in the course of a few weeks or months, and yet these may be only the forerunners of severe symptoms.

Some years ago Dr. Buzzard put together all the cases in which he had diagnosed functional paralysis and afterwards discovered he was wrong, and almost all without exception, were cases of disseminated sclerosis. Remember therefore cases of disseminated sclerosis may present various paralytic conditions, which come and go, and which you will be apt to call functional. But possibly such symptoms have an organic basis, and you must therefore be careful to avoid saying that there is nothing seriously the matter with the patient and that he will recover, because they may indicate the onset of an incurable disease which will cripple him for life.

Another mistake often made is between functional paralysis and the early stages of general paralysis of the insane. Such a patient may have various nervous symptoms which come on, and after lasting a short time, pass off, which are apt to be regarded as functional. But if you bear in mind that there are generally evidences of other degenerative changes, in general paralysis of the insane, such as syphilitic lesions or mental failure, you ought if you are careful to avoid the mistake.

Another group of cases in which mistakes may be made are in the early stages of interstitial nephritis. With granular kidneys some patients have temporary aphasia, or temporary paralysis of a limb. This clears up in a short time, apparently leaving no permanent trouble, and yet it would be unwise to give a favorable prognosis, because it is quite certain that such attacks will recur and become increasingly severe.

I will now put before you the salient points of the case we are especially considering to-day. The report is a very long one, and has been carefully drawn up by a succession of Ward Clerks, Messrs. Maybury, Moiser, Nunn and May, and I only wish to direct your attention to the special features of the case. The woman was 29 years of age, and unmarried. Practically for the last nine years she has been a chronic invalid, having been able to do nothing,

and been confined more or less to her bed. The trouble commenced in 1893, when she had a dragging pain in the left side of the abdomen. During the next year or two her left leg and foot became firmly flexed, associated with great pain in the left side. In 1895 she had some operation performed at the Hospital for Women, Soho. The leg was put in a splint and forcibly extended, and eventually became straight again. The pain in the abdomen persisted, and she was unable to walk. She has for years only got about on crutches, dragging her left leg; the right leg is perfectly normal. Last January when sitting up in bed she heard that somebody in the house was very ill, and she became frightened and had an attack of pain with dyspnœa; shortly afterwards she was found with both her legs strongly flexed, and it was not possible to extend them. For some time her lips and teeth were firmly clenched, her arms were helpless but not rigid. It was found that she had lost the use of the muscles of her back. Next day she was able to slightly move her arms and her right leg. They gradually improved, but the back remained powerless, and the left leg almost completely paralysed. The patient was very feeble. She has had a tendency to retention of urine, but has never had a catheter passed.

When admitted, in June of this year, the movements of the head and neck were normal, that of the left arm was extremely feeble and the patient was unable to separate her fingers. There was slight but not very definite wasting of the muscles, and the abdominal reflex was present. She lies with her left leg stiff and rotated inwards, the foot dropped and inverted and the toes pointed, and is unable to move her toes or leg. She cannot raise her heel off the bed; the only movement is a slight one of flexion at the knee. She is unable to move the thigh, but the limb offers resistance to passive movement. Sensation is completely lost over the left foot and ankle and it is impaired for some distance above but the limit constantly varies. She does not know the position of the limb. Behind, the anæsthesia extends up to the tenth space. Sensation to heat and cold are normal. Although the right leg was very feeble there was no definite paralysis. The knee-jerk on the right side is slightly exaggerated, and on the left more decidedly so. There is no ankle clonus. The plantar reflex is very feeble and of flexor type. There was a little doubt as to whether there was any nystagmus; we soon decided there was none; otherwise she was healthy. She remained in bed for a long time, she was frequently stimulated, faradised and massaged, and was gradually induced to make an effort to use her limbs. All the muscles reacted to Faradism and Galvanism, though very feebly in many cases. She was isolated and put on Weir Mitchell treatment. Towards the end of June she recovered some power in her left arm. The joints were gradually moved an increasing amount.

July 4th. The movements of the left arm are feeble but otherwise perfect. She is now recovering some power of movement in the left leg.

Marked lateral curvature of the spine.

She slowly improved, but there is no power to rotate the left thigh either in or out, and the movements are all feeble.

In October she began to walk about again, with assistance, but marked inversion of the left foot necessitated the use of a suitable boot. The leg dragged feebly. She left at the end of October, having greatly improved, the only marked defect being in the movement of the left leg.

There was no single sign which was positive evidence of organic disease, and most of her symptoms ultimately cleared up. She had her joints moved regularly, and although the progress was slow she gradually improved. The electrical reactions of all her muscles were normal; there was no atrophy of any muscles. After a time we got her up and induced her to walk. She gradually recovered the use of her left arm although the movements were very feeble. She used her right leg normally, but the movement of the left leg was always very imperfect. Her gait was very curious. She dragged her inverted left foot along the ground, being unable to abduct or to raise it. The tendency was to carry the leg over to the right side in front of and across the right foot, making it impossible for her to walk without some help or a crutch. The very marked inversion of the foot present in this case is very typical of functional paralysis, so

that it is very probable that she will ultimately recover the use of her left leg. But as there is a history of paralysis for several years secondary contractions have taken place and the muscles take a long time to recover. It is just possible that there may be some organic change; because if a patient has paralysis of a muscle, even if it is only functional, yet if it lasts five or ten years, and the joints have not been moved all that time, the unopposed muscles contract, and it is a question whether changes do not also take place in the spinal cord. Professor Charcot lectured for many years on certain cases as typical of hysterical paralysis, and in more than one instance, when the patient died, organic disease was found in the spinal cord. But whether or not there is an organic lesion underlying all this patient's symptoms, the great majority were functional and have, under treatment, passed away.

I will now put before you the various reasons which would induce you to look upon paralysis as functional.

1. *Personal and family history.* In such cases the presence of degenerative changes, such as heart or kidney disease, would be suggestive of sufficient cause for organic nervous disease, especially in infants and children. If the patient is neurotic and the family surroundings are such as would allow self-control to be in abeyance, it would be in favour of functional disease. In such patients you generally find patches of anæsthesia, a history of hysterical attacks, and other evidence that the individual is neurotic.

2. *Mode of onset.*—Many cases of functional paralysis come on immediately after shock or emotion, excitement, or traumatism, whereas if the paralysis comes on in sleep or during violent exertion (paralysis often occurs with elderly people during coitus or defecation), it is more likely to be organic than functional. Apoplexy is unknown in functional disease. If the onset is with definite loss of consciousness and a condition of coma develops, you may be quite certain that you are dealing with organic disease. Sometimes cataleptic conditions with stupor and mutism occur in functional disease, but this is quite different from apoplexy. There is no stertorous breathing, no disturbance of circulation nor raised temperature, nor complete loss of control over the bladder or rectum. Conjugate deviation of the eyes and aphasia are in favour of organic disease. In organic disease paralysis comes on slowly, unless there has been a sudden attack with loss of consciousness, and improvement also is gradual. But in most cases the onset of hemiplegia in organic disease is not at all sudden.

3. *Characteristics of functional paralysis.*—The arm and leg may both be involved on the same side or only one limb, but practically never the face. If a functional lesion involves the face, the condition is one of spasm and not paralysis. In two-thirds of the functional cases the left side is affected. As a rule the leg is more affected than the arm, and a patient with functional hemiplegia walks with the leg as an inert mass. A patient with ordinary hemiplegia due, say, to cerebral hæmorrhage throws his body to the opposite side and circumducts his leg, whereas the patient with hysterical paralysis drags his foot along on the ground and often inverts it so that the mode of gait is generally quite distinctive.

In functional paralysis anæsthesia is often very extensive and usually very profound, so that there is a complete loss of sensation to all forms of stimuli, whether of pain, heat, cold, or touch. The anæsthesia often involves the special senses as well, and not infrequently it is associated with blindness in one eye. In organic disease the ocular defect, if any, is one of hemiopia, a condition which never occurs in functional paralysis. The anæsthesia in functional paralysis does not follow the distribution of any nerves, but has a glove-like distribution, a distribution round the limb, and it will vary from day to day and be quite inconstant.

Amonoplegia, absolutely limited to one limb, with anæsthesia glove-like in distribution, following traumatism is functional and not organic.

Defects of vision in functional paralysis. Not only may there be amblyopia of one eye, but the field of vision is very apt to be contracted. A contraction of the field of vision with no local lesion in the eye would suggest functional

trouble. Hemiopia is indicative of organic disease, except with migraine.

As to the deviation of the tongue; this in organic disease is due to paralysis, but in functional disease, if it occur, it is due to spasm and not paralysis, and is very variable.

4. *Course.* — In functional paralysis the changes are sudden, not gradual. With organic disease the paralysis gradually tends to decrease; whereas in functional paralysis changes are frequent. At the onset, in organic paralysis, there is never rigidity, but it only comes on after a certain time; gradually increases and becomes well marked after a few weeks; whereas in functional paralysis the rigidity comes on very often with the onset and remains indefinitely without altering or varying from day to day, quite different from the progressive rigidity which occurs in organic paralysis.

Contractures gradually develop in organic disease, and it is very rarely indeed that an organic hemiplegia occurs without well marked contracture within three months, whereas in functional paralysis the limb may remain flaccid for months without any rigidity ensuing; when there is rigidity the spasticity varies, and the wrist can be extended without thereby flexing the elbow.

If you lift a patient up by one leg in functional paraplegia, you generally find that the other leg is not raised. If one leg follows the other, there is organic disease.

Knee-jerks and superficial reflexes.—When the muscle tone is increased the tendon taps become exaggerated. On the other hand, when there is a deficient tone in the muscle, the tendon taps tend to diminish and disappear. The tendon taps are not necessarily altered in functional paralysis. When the knee-jerk is permanently lost, the disease is not functional, but some reservation must be made. It is sometimes difficult to elicit the knee-jerks, and you must not be satisfied with merely one examination. You may fail to obtain the knee-jerks partly because the patient holds his limb too rigidly, and sometimes also in very feeble conditions, but if you repeat your examination, and are careful to keep the limb perfectly flaccid, and put the tendon on the stretch, the knee-jerk should be obtained. It is also a little difficult to explain why, but in some cases of meningitis, and also in some gross cerebral lesions, the knee-jerks will disappear. In lesions of the cerebellum it is much more rare for them to be absent; they are more often exaggerated. Still, there are undoubtedly some cases in which they have disappeared. It is certain that we have yet more to learn as to the causation of the disappearance of the knee-jerks in these cases. But in healthy individuals the knee-jerk is practically always present, so that that is a very valuable physical sign to which we have to pay attention. It is not at all infrequent in functional paralysis to find a moderate increase of knee-jerk with a momentary ankle clonus. You want to draw a distinction between an ankle clonus which is persistent and lasts for half a minute—particularly if it is elicited when the leg is kept quite straight (such is never functional)—and the brief clonus which we meet with in conditions of exhaustion. A typical ankle clonus which is started by percussing the tibialis anticus, with the tendo-Achilles held on the stretch, is never met with in functional disease.

The cutaneous reflexes.—The plantar reflex is an extremely constant physical sign. It is comparatively rarely that you fail to obtain it in health, except when the feet are cold or wet, but it often may be absent with functional paralysis. The typical reflex, on stroking the sole of the foot, is a flexion of the toes. Babinski, some four years ago, drew attention to the fact that in cases of perturbation and disturbance of the lateral column, usually due to organic disease, stroking the feet will produce extension instead of flexion of the toes. I will discuss the phenomenon more fully later. But this extension of the toe which goes by the name of Babinski's sign, or the "toe phenomenon" is not met with in functional disease. It is, however, not always present with organic disease. In organic disease of the lateral column, you only meet with the extensor phenomenon in about 80 per cent. of the cases; in 20 per cent. the flexor phenomenon is still present. On the other hand, the extensor phenomenon is not met with in healthy people.

The only cases in which it has been met with, outside disease of the lateral column, are a few cases of tabes and of alcoholic paralysis. It is just a question with regard to such cases, whether there may not possibly be some cord change in the lateral column, as well as elsewhere. But excluding tabes and alcoholic paralysis, the presence of an extensor reflex would justify you in assuming that the disease is not a purely functional one.

Bed sores.—Acute trophic bed sores never come on in functional paralysis. The rapid development of bed sores always indicates organic disease.

Additional evidence of organic disease may be furnished with regard to certain ocular conditions. *Optic neuritis* and *optic atrophy* are absolutely conclusive. The difficulty which arises is sometimes in being quite certain whether the ocular appearances are indicative of neuritis or atrophy, as the case may be. With hypermetropia and in certain toxic conditions the discs may be hyperæmic and swollen and the appearance is often mistaken for optic neuritis. Again, there are many discs which you would be inclined to call atrophic, if you judge only from their appearance, but in which the field of vision is perfectly normal, and which are not necessarily indicative of organic disease. You must then be careful in estimating these signs that what you suspect to be neuritis is not merely hyperæmia, and that you show the field of vision to be defective before you diagnose a white disc as atrophic.

Definite continuous paralysis of the ocular muscles almost without exception indicates organic disease. Hemiopia indicates organic disease.

Electrical reactions of muscles and nerves.

When a muscle and the nerve supplying it fail to react to faradism and the muscle reacts to galvanism with a sluggish instead of with a quick contraction, while the response to the anode closure is better than that to the cathode, the reaction of degeneration is present and is always indicative of an organic lesion of the lower neuron.

In all cases of wasted muscles it is important to test them electrically, and you must not conclude that there is a reaction of degeneration because you have failed to obtain a contraction. The failure may simply be due to the fact that the skin is cold, the circulation sluggish, and the cutaneous resistance is so great that the current that passes is insufficient to produce a contraction. In testing muscles with the continuous current you must always use a galvanometer. In functional disease there is never localised atrophy of special muscles.

The condition of the bladder. Retention of urine is common enough in functional disturbance, but incontinence of urine may be looked upon as evidence of organic disease, assuming that the patient is an adult and that the defect is not due to a disturbed mental state. I have referred to a number of physical signs, and although, taking any one of these signs alone, the evidence might not be sufficient, yet taking them all together you are generally able to come to a definite conclusion.

As to the deductions to be drawn from variations in the *plantar reflexes*. The best way to elicit the plantar reflex is to have patient lying down with the muscles of the leg relaxed, the knee flexed, and the leg lying on its outer side. Stroke somewhat firmly and slowly along the sole of the foot, by preference along the inner side. The first muscle to contract is the tensor vaginæ femoris. With a normal reaction there is also adduction and flexion of the toes, and the foot tends to be inverted. If the reflex is at all brisk there are also dorsi flexion of the foot, flexion of the knee and abduction of the thigh. In disease of the lateral column, you find that instead of the toes flexing the most marked change is a slow over-extension of the great toe, with separation and extension of the other toes. But in a small number of cases the small toes will flex and great toe extend. With a mixed reaction, there is some difference of opinion as to how much stress is to be laid upon the different reflexes. The normal reflex is the flexor, the centre for this reflex is probably in the cerebral cortex, and therefore its presence necessitates that the cortico-spinal fibres should be intact. The extensor reflex is probably a distinct reflex, having nothing whatever to do with the flexor. It is, however, only when the

flexor reflex is in abeyance that the extensor is obvious. The more potent reflex being in abeyance, the less potent one is brought out. The extensor reflex probably has its centre in the medulla and not in the cortex.

The extension of the great toe with flexion of the small ones would result when the flexor reflex is not completely lost. It is also worth noting that the extensor reflex when present can often be elicited by stroking over the posterior surface of the thigh.

The value of the condition of the plantar reflex as an indication of disease was summed up as follows by Dr. Epps:—

A. Out of 500 patients, free from organic nervous disease, the plantar reflex was absent on both sides in 3·8 per cent., on one side in 2·2 per cent., of a doubtful extensor type in ¼ per cent, and in only one case was it typically extensor (here possibly some meningitis was present). The plantar reflex may be absent when the feet are cold or perspiring freely, and in hysteria.

B. Out of 213 cases of nervous disease in which the lateral columns were not involved the flexor type was present in 78 per cent., absent in 18 per cent., extensor in 2 per cent. (four cases of tabes and one of neurasthenia).

C. Out of 62 cases with a lesion of the lateral column there was an extensor reflex in 63 per cent., flexor in 26 per cent, and none in 11 per cent.

D. Out of 118 hemiplegic patients there was extension in 57 per cent., flexion in 30 per cent., mixed reaction in 5 per cent. and none in 8 per cent. In nine cases there was an extensor reflex on the opposite side. What I wish particularly to emphasise is that in 35 out of 118 patients suffering from definite organic disease in the lateral columns, there was a flexor reflex. Therefore you are not justified in saying that if there is a flexor plantar reflex there cannot be organic disease of the lateral column; but you are justified with an extensor reflex in saying there is organic disease.

The extensor reflex is present for a short time, immediately after convulsive movements whether due to hysteria, plumbism or strychnine poisoning. If you exclude these cases, the extensor reflex is a very valuable sign in connection with the diagnosis of organic disease, more particularly in disseminated sclerosis. If you have an obscure paralysis of a limb, and you find the patient has a well-marked extensor reflex, you may be perfectly certain that you are not dealing with functional paralysis. I perhaps ought to emphasise still more, that a well-marked flexor reflex on one side with an extensor reflex on the other, is conclusive of organic disease. The value of the sign is very great, as it developes very early, before any other evidence of disease in the lateral columns of the cord.

Cutaneous reflexes and tendon taps.—Tendon taps are not reflex, as the time taken in eliciting them is less than physiologists tell us is necessary for a reflex process, but they depend upon the condition of the muscle tone. Grasset, Gehuchten and others have suggested that there are three groups of centres regulating the reflexes; but their views, although a great advance in our knowledge, do not explain all the facts.

1. A *spinal.*—In the anterior horns for simple quick defensive reflexes.

2. A *medullary* in the red nucleus and possibly connected with the pons and cerebellum. From this red nucleus the fibres run, as the "rubro-spinal" or Monakow's tract, above the olivary body and in the anterior part of the lateral column, to regulate the muscle tone and indirectly the tendon reflexes.

3. A *cortical* near the Island of Reil and the motor cortex. Fibres run as the "cortico-spinal" tract and regulate the cutaneous reflexes. With an organic cerebral hemiplegia the tendon taps are exaggerated and the cutaneous reflexes diminished or lost. When the cortico-spinal tract is damaged, the cutaneous reflexes disappear. On the other hand, the abdominal reflex is often exaggerated when the knee-jerks are absent, as in tabes.

A spastic paraplegia may be associated with the flexor type of plantar reflex, and in this case the lesion is *probably* functional; if with the extensor type it is certainly organic.

I have now only time for a few words on the differentiation between disseminated sclerosis and functional paraplegia.

The insidious and gradual onset of the former disease, is why a mistake in an early stage is so often made. Attention to the following may often save you from making a mistake. (*a*) An extensor plantar reflex is conclusive against a functional lesion. (*b*) A white optic disc with a central scotoma, or a limited field of vision is equally so, but the mere appearance of the disc alone will not be conclusive of disseminated sclerosis.

(*c*) The other symptom is nystagmus. It is very difficult to be quite certain in the early stages of nystagmus—as to whether it is really present, or whether the muscles are merely feeble. In this patient, for instance, at the onset there is a statement that nystagmus was present, but on examining the patient on many subsequent occasions we satisfied ourselves that there was no definite evidence of it. The definite presence of nystagmus would be very important, and against a merely functional disturbance. Bearing in mind these three phenomena, any one of them being quite characteristic, would probably save you from diagnosing a merely functional paralysis when more serious trouble was developing. It is very curious that, in this country, central scotoma of vision in connection with disseminated sclerosis has been overlooked until the last few years. Uhthoff was first to draw attention to it abroad. You will not notice a central scotoma unless you look for it in the proper way. One method is to use a *small* white or coloured spot on a piece of black paper, making the patient keep his eyes fixed on a definite place, when the coloured spot disappears as it is moved about on reaching the blind area. The area is most readily plotted out with a perimeter. It may be that the scotoma is not very large, and unless you take a small object you will never discover the scotoma. But if you look out for it you will find that it is not very rare in the early stages.

Appointments.

CIVIL.

MOON, R. O., M.A., M.D., M.R.C.P., has been appointed Physician to Out-patients at the Infirmary for Consumption, Margaret Street, W.

SHARP, H. C., M.B., B.C. Camb., has been appointed Medical Officer of the Kenwyn District of the Truro Union.

Prize Examinations.

COMPETITION for the undermentioned Prizes will take place on the following dates:—

THE ARTHUR DURHAM PRIZES FOR DISSECTION.—Monday, March 9th, 10 a.m.

JUNIOR PRIZES FOR GENERAL PROFICIENCY.—Wednesday, March 18th, 10—1, Elementary Anatomy; 10—1, Anatomy; 2—5, Physiology. Tuesday, July 21st, 10—1, Histology.

MICHAEL HARRIS PRIZE IN ANATOMY.—Wednesday, March 18th, 10—1. The date of the Practical Examination will be announced later.

WOOLDRIDGE MEMORIAL PRIZE IN PHYSIOLOGY.—Wednesday, March 18th, 2—5. The date of the Practical Examination will be announced later.

SENIOR PRIZES FOR GENERAL PROFICIENCY.—Wednesday, March 18th, 10—1, Clinical Medicine; 2—5, Medicine. Thursday, March 19th, 10—1, Clinical Surgery; 2—5, Surgery. Friday, March 20th, 10—1, Public Health. Monday, July 20th, 10—1, Pathology; 2—5, Midwifery and Diseases of Women. Tuesday, July 21st, 10—1, Pharmacology and Therapeutics; 2—5, Mental Diseases. Wednesday, July 22nd, 10—1, Medical Jurisprudence.

BEANEY PRIZE IN PATHOLOGY.—Monday, July 20th, 10—1. The date of the Practical Examination will be announced later.

TREASURER'S MEDALS.—Tuesday, June 9th, 10—1, Surgery; 2—5, Medicine. Wednesday, June 10th, 10—1, Commentary on a Case in Medicine; 2—5, Commentary on a Case in Surgery. Thursday, June 11th, 10—1, Clinical Examination in Medicine. Friday, June 12th, 10—1, Clinical Examination in Surgery. Operations to be announced later.

GOLDING-BIRD GOLD MEDAL AND SCHOLARSHIP IN BACTERIOLOGY.—Thursday, March 26th, 10—1, Paper; 2—5, Practical. Friday, March 27th, 10—1, Viva Voce.

DENTAL PRIZES (First Year's Students).—Tuesday, March 24th, 10—1, Metallurgy; 2—5, Anatomy. Wednesday, March 25th, 10—12, Physiology; 2—5, Dental Anatomy. Friday, March 27th, 2—5, Dental Surgery. Monday, May 25th, 9 a.m., Conservation Room Examination. Thursday, May 28th, 2 p.m., Clinical Examination. Saturday, May 30th, 9 a.m., Laboratory Examination. (Second Year's Students). Tuesday, March 24th, 2—5, Anatomy. Wednesday, March 25th, 10—12, Physiology; 2—5, Dental Anatomy. Thursday, March 26th, 2—4, Surgery. Friday, March 27th, 2—5, Dental Surgery. Monday, May 25th, 9 a.m., Conservation Room Examination; 2 p.m., Clinical Examination. Saturday, May 30th, 9 a.m., Laboratory Examination. Friday, June 12th, 9 a.m., Special Examination for Prize for Practical Dentistry. (1904 Prize). Friday, July 24th, 2—5, Operative Dental Surgery (paper). Tuesday, December 15th, 2—5, Dental Mechanics (paper).

SCHOLARSHIPS IN DENTAL MECHANICS.—Thursday, April 30th; Wednesday, September 30th.

Passim.

THE Second Half of the Winter Session has now begun, and all work is in full swing, and we now begin to look forward to the spring. The only landmarks between us and the summer are the Rugger and Soccer Cup-ties, and the brief holiday of Easter. It is without exception the worst part of the English climate and one that many flee from. It has set in with a striking cold snap and rumours of skating fill the air, and we have noticed a corresponding fall in the Influenza epidemic, which appears from the papers to attack the high and mighty in the cold seasons, but us poor mortals only with increasing damp and depressing thaw.

THE Christmas Theatricals and Ward Funds are not balanced properly. There is a deficit on both, and we have no hesitation in welcoming subscriptions for either, as otherwise the charges fall on those who really cannot afford to pay. There can be no doubt that faced with the abolition of either the Nurses' Christmas Entertainment, or the Ward Decorations and Festivities, that many would step in who now hold aloof. In one ward the total receipts towards the Christmas Festivities was 8s. 6d. ! ! And it is most unfair that the expenses of entertainment even carried out in the slightest and most retiring fashion should, except for that small sum, fall entirely on the Sister, the Resident, and Nurses of the ward. We are far from approving of the lavish expenditure and think that the ward expenditure, the usual "tips," etc., in fact the whole system of Christmas is too expensive. It is, we feel, most unfortunate and undesirable, to say the least thing, that any Sister should have to be obliged to calculate on a personal expenditure of several pounds on unavoidable expenditure when her pocket is, with the exception of the self-taxation of the Residents and Students, the only source of income.

THE Out-patients' Christmas Tea proved as usual a great and overwhelming success and amply repaid the exertions of its promoters. Here in great contrast to the other funds is to be found a comfortable income and a large balance to carry over. Partly owing to their foresight, but chiefly to their energetic begging, the authorities had tapped many charitable purses before the Residents had been with difficulty induced to face the question of the Christmas entertainments, and there can be little doubt but that the early start deprived the older funds of some money. Want of foresight is partly responsible for this, but it does seem that the money might be distributed and raised by a common board, so that the future coat may be cut according to the cloth. In another number we hope to publish the accounts of the various entertainments to point the moral. At the same time we are deeply grateful to the great liberality of several of our Staff, to which we shall refer to again later.

A GREAT deal has been made of the Bart.'s proposal, or rather plan, to buy six acres for a quarter of a million, and then raise three-hundred thousand for the necessary buildings. But if the hospital was cramped, extension was absolutely necessary, and it has never been denied that they were severely cramped, and of what use would the additional space be without the buildings on it? Also if the income was sufficient for the small and cramped space, how could they exist if they lost that income by realising their investments for the new buildings? This much, if true, and we take it from the newspapers which are running riot over their plans, disposes of the mass of cheap American criticisms so common nowadays, but we think there is a good deal of opposition that Bart.'s will have to reckon with, to their line of action.

THE trenchant criticisms that Bart.'s has drawn upon itself may be considered in our case. We have no cramped site, no vanishing population except from the compulsory diminution of over-crowding, no large endowments, and we are in many things well equipped; our work is heavy and difficulties still great, but the work is urgent, and we know the public will not let it stop. It is freely alleged that the appeal was made at an awkward moment for the London, and that as it is unfortunately

notorious that most successful appeals draw off support from other institutions, we can only say we believe the need of the London and its vast poor area to be a factor of prime importance, and one that should take precedence of St. Bartholomew's, whose riches are great, undeniable and increasing. So that the accusation of rather too clever—if not actually—a sharp practice, if we understand the London chairman aright, will have to be faced before any great measure of public support is elicited.

THE second point is that Bart.'s, to its honour and pride, is an ancient, honourable, and unreformed corporation, and unreformed usually means needs reform, and from all we hear, we only quote the common report, there is an opportunity to press on unwilling Governors and others changes that will tell for greater efficiency in the appointments and position and customs of the place. Guy's, in the days of her power and affluence, scorned to allow any publication of her deeds, her properties, her payments and so forth, but stern necessity was the mother of the many alterations which have been so extremely to our benefit in the last decade or so. In fact, if the City and the public is to support Bart.'s, a friendly commission of enquiry into the arrangements and constitution will be found, we believe, a boon in the end, if unwelcome. It is almost needless to point to the good the Public Schools and Universities Commisioners did in spite of vehement opposition.

FURTHER it must be considered whether in view of the fact that the need of the London is so great, that their work is so vast, and, we believe, so well and so efficiently performed, it is fair to appeal at the same time as their quinquennial appeal. We need hardly say that our modest endowment of roughly £25,000 as compared with Bart.'s endowment of £70,000, much more than our expenditure, leads us to sympathise with the London as we are in a very similar position and serve much the same class of population who have no alternative to go to. However, it is more fair to await the official statement, though, as it cannot be withdrawn when once launched, criticism of the action must be to a certain extent made in the dark if made at all.

IN making these remarks we do not wish to say one word that may be twisted into criticism of the Hospital. We believe its work is good and as great as our own, but is their need as great as ours and the London's? because it is certain *all* will not be provided with ample funds. At all events, we wish success to the London's appeal and to the Bart's appeal if they do not damage other struggling and worthy institutions.

THE generous benefactions that have been received by St. Thomas', the Children's Hospital in Great Ormond Street, and by the Evelina, lead us to hope that there is somewhere some benevolent testator with a similar intent in store for us, and assuredly if we are to come up to our ancient position in material, and to keep in the van, more money must be raised.

As the Inter-Hospital Rugby Cup ties draw near—Guy's being drawn to play Middlesex in the first round on January 27th—the eyes of all are fixed on the achievements of our XV. The form shown at Catford Bridge on Saturday was very gratifying. After a most exciting game we retired victorious by one try to nil. Unfortunately the services of O. V. Payne are lost to us owing to injury, O'Brien takes his place at half, making room at centre for L. J. J. Orpen, who is at present in excellent form and sound in limb again. E. Morgan, too, for some weeks has been suffering from an injured ankle, but will, we trust, be so far recovered as to represent the hospital in the cup ties. Meanwhile his place is most ably filled by H. S. Brown. Bearing in mind the form displayed by the team against Cambridge, the O.M.T.'s, and Catford, we have every confidence that the cup will remain at Guy's.

THE draw for the Rugby Cup, which appears elsewhere, points out the enormous advantage of being lucky. Lucky in draws for the Cup we never were. Almost every year we have had to meet three out of five of the strongest Hospitals and to play a hard game in each

round, and this year forms no exception to the rule. To win we shall have to defeat Middlesex, Bart's, St. Thomas's, and the London in succession. It would be impossible to arrange a stiffer ordeal for us, or an easier one for the London. Such is luck, whose very existence some are inclined to deny. It is a most curious coincidence, speaking from memory, that we have almost always played St. Bart.'s, St. George's, and the Middlesex, and that we have rarely met St. Thomas's since we wrested the Cup from them; before which time they usually proved our downfall.

IT also gives a very unfair impression of form, in that the finals have often been between the winner and a poor rival, and the second strongest team has less gloriously perished after a fierce fight in the first or later rounds. Besides the number of rounds means a severe strain on the players, who often deteriorate, and a risk of accident, which may cost a side dear. Still, no fairer arrangement can be made if the prize is to be fought all over again every year with equal chances for all.

THE Committee charged with the carrying through of the Memorial to Guy's men fallen in the South African War, is approaching the completion of its labours. The list of names of those to be commemorated has been completed, Mr. Frederick Wheeler's plans for the drinking fountain in the Colonnade have been approved, and contracts for the carrying out of the work entered into. It is understood that the work will be proceeded with forthwith.

IT is always held to be the duty of the man in the street, or in the house, to close up his accounts at the end of the year, pay his bills, send out his own, and start the new year with a host of new resolutions often founded on disgust at the past. As with individuals, so with Corporations, and Guy's is peering forward into the future to see what will happen or may be intelligently anticipated.

IT is to be expected that the South African Memorial will be finished this year, though we are not in our private capacity enamoured of the adopted proposal. However, it was the child reared we may say by the GAZETTE Committee of two years ago, and it will ill become us to disown it if it has not ripened as was hoped. The position is that a general meeting was held and certain definite lines of action to be followed, if possible, were delegated to a special committee, The Committee found itself in a position to carry out the exact line the general meeting apparently wished, and consequently the memorial is settled on beyond recall. It will be, we understand, without official knowledge, a drinking fountain on the Colonnade wall of Astley Cooper near the Quadrangle, and will bear a suitable inscription which, if "militantes" covers the Red-cross service and status of non-combatants is neat and accurate, but we do not hold ourselves responsible for the correct classic use.

OTHER things we look forward to is renovation of the remaining wards, the opening finally of the new beds as Female Medical Beds, the opening of the Wills' Library, and the institution of the "Drunk or Dying" Room, to use a vivid and explanatory headline, and also the necessary increase in the Theatre accommodation.

WE hope to see the Rugger, Cricket, Soccer, and the long lost Mellin Shield return to its rightful owner, and last and not least, may the entry of the right sort remain and increase.

THE notice in another column of the vacancy for an Obstetric Registrar is we imagine the official method of calling attention to the impending departure of Dr Galabin from the active ranks to the Consultant Staff. He has been for so many years our senior obstetrician, and so regular and methodical in his attendances and services, that the wards in which he worked will seem more than usually altered by the change. Six months ago, the white haired sister who is no more, and the Dr. Galabin she was so closely attached to, were so integral a part of Queen that no one could have contemplated without deep regret the possibility of any alteration, and yet it has come to pass, and a chapter in the history of Queen will be closed that probably will find no parallel in its simplicity and success.

WE should like to call the attention of both past and present Guy's men to the Annual Dinner of the Debating Society, which is to be held on Saturday next, January 24th, at 7.30, in the College Dining Hall. The Society is in a most flourishing condition, and the debates are better attended than they have ever been before, the most hopeful feature being the number of maiden speakers. What should ensure the attendance of all at the dinner is the fact that the Society's president, Dr. Savage, will not only occupy the chair, but will also deliver an address, after the dinner, on his "Reminiscences of Guy's." Dr. Savage's reminiscences, many and varied as they must of necessity be, will, we are sure, prove exceedingly entertaining, and we counsel all to see that they procure tickets before it is too late.

THE *Climate* contains a note couched in quite the 20th century style on the prospects of an Imperial combine to stamp out Malaria by the systematic drainage of swamps, and inspection of the lurking places of the notorious mosquito. Without wishing to throw cold water, we can only feel that the onlooker's position must for the present be one of doubt as to even the theoretical possibility of this method of extermination, and further, of the possibility of putting it into practice. It seems to us that as so, the drainage of all stagnant water is rather a large undertaking if that is what the theory amounts to, but we should welcome enlightenment on the subject. There is a most interesting paper by Major Ross, F.R.S., in which he treats of the definite case of Ismailia, and thinks the extinction of Malaria there quite within the bounds of possibility, and points out the methods. It is well worth reading, even by the non-travelling Englishman.

AN Index and Title-page to the volume for 1902 have been prepared, and may be obtained at the Library. Subscribers can have their sets of the GAZETTE bound in blue cloth, with the Arms of the Hospital in gold, for One Shilling and Sixpence, by leaving them with the Librarian as early as possible. We may remind our readers that the annual subscription of Seven Shillings and Sixpence is now due, and should be sent to Mr. C. H. Wells, Guy's Hospital.

Guy's Hospital Physical Society.

THE fifth meeting of this Society was held in the Library, January 14th, 1903, Mr. J. M. Brydone in the chair. Clinical cases were shewn.

Mr. COOK showed a case of Paramyoclonus Multiplex.

Mr. BARBER supplied some further information about this rare disease.

Mr. BOWEN showed a man with a swelling at the root of the neck. The man was æt. 52, was married, but had no children. He first noticed the lump two months ago, and it has increased rapidly in size since then. It is seated over the inner end of the clavicle with which it is firmly connected, the bone undergoing some enlargement as it approaches the mass. It is fluctuating in the centre, firm at the bone. The man has numerous scars about his body the result of old syphilitic lesions. It is diagnosed as a gumma, and the man is being treated with potassium iodide. He had not been treated previously.

MR. BARBER asked for information in reference to the incising of gummata.

Mr. BRYDONE remarked that it was very seldom that one met with a case nowadays of syphilis which had gone so long without treatment. He did not see why so large a gumma should not be healed surgically and antiseptically.

Mr. BOWEN did not think that the two conditions were at all comparable; in the case of the syphilitic buboes which suppurated, this was a secondary infection with some pyogenic organism, and the usual surgical treatment of evacuating pus was indicated. In the gumma one was dealing with a mass of necrotic tissue, and the result of incision would be a wound which would heal but slowly on account of feeble nutrition.

Mr. WRENCH proposed that mercury should be given in this case, as the man had not been treated in the early stages of the illness with this drug. It appeared that mercury was required at some stage of the disease.

Mr. ROBSON, referring to this same point, wished to know whether potassium iodide was any good in cases which had not been treated previously with mercury.

Mr SPRIGGS wished to know whether mercury was stored up in the body, as this would be the only obvious explanation of the remarks made by the previous speakers.

Mr. BOWEN showed a man whose knee had become swollen and stiff as the result of an injury received three months ago. He had been unable to walk on it since. The bony landmarks of the knee were obscured, movement was considerably limited, and the joint was tender on pressure. The swelling was somewhat uneven in consistence, being firm in parts, softer and suggesting fluctuation in others. The diagnosis lay between tuberculous disease and growth. The latter was excluded as the swelling was obviously in the knee-joint. The question of treatment at this age was referred to.

Mr. BARBER asked whether legs wasted as much at forty-five in connection with joint disease as they did at the age of four or five. He had not noticed that this patient's leg was much wasted.

Mr. WRENCH thought that in the absence of starting pains and other signs of extensive disease in the joint, some treatment less radical than that of excision should be tried first, such as injection with iodoform. Even should the mischief extend it would be of less importance than in a child, as the risk of injury to the epiphysial lines was not present at this age.

Mr. BOWEN did not consider that Mr. Wrench's suggestion should be carried out. If the disease became extensive, excision would be useless, and amputation through the thigh, with the grave risk to life that this entailed, became the only alternative. He compared this prognosis of tuberculous disease of the lung and of joints in the young with similar disease in those over forty-five.

Mr. BRYDONE, speaking of the results of excision, said that cases frequently left the hospital with tuberculous deposits still existing, as shown by the presence of sinuses, and that a prolonged stay in the country or by the sea was necessary for the final cure. He thought that the country air should be given credit in the cure, and thought that in many cases that the change to the country or seaside would alone suffice. As regards erosion, he doubted whether movement was as often obtained by the employment of this operation as was claimed.

Mr. TESSIER showed a case of right ophthalmoplegia in a woman of thirty-five, associated with left hemiplegia. The eye symptoms had preceded the hemiplegia and they were apparently due to two separate and distinct lesions. Both were regarded as due to syphilis.

Death Certificates.

THE signature of a death certificate is one of the earliest and occasionally one of the most embarrassing results of completing the "Colleges" and paying a large fee. It may be safely affirmed that few men, if any, sign a certificate for the first time without consulting older men. From the annexed list the younger practitioner will be able to select the correct designation if they have diagnosed it, or hide their uncertainty by the use of italics. Among the latter, however, we must confess that the term ovarian tumour implies a lot of definite information that we should find a difficulty in expressing more accurately. It would also have been useful if a few more hints on death certificate signature had been appended, for instance, the filling in of the second line.

It is highly desirable that Medical Practitioners should use, in their Certificates of Death, only those terms which are recognised by the Royal College of Physicians of London.

The list of diseases now used in the Registrar-General's Reports, *vide infra*, is condensed from the Nomenclature of the Royal College of Physicians, with the addition of certain unofficial terms which are still in common use, but which are objectionable, either as being the names of symptoms merely, or as being otherwise indefinite. In the copy of the list here given, these objectionable terms are printed in *italics*: and it is hoped that Medical Practitioners will use them only when accurate information is wanting.

1. The cause of death should be stated precisely and briefly; English names for diseases being used in preference to their equivalents in other languages. Vague terms such as *decline, consumption, tabes, cachexia, &c.*, should be avoided; and *hæmorrhage* should not be assigned as the cause of death without indication of its origin and probable cause. *Dropsy* should never be returned as the cause of death without particulars as to its probable origin, *e.g.*, in disease of the heart, liver, kidneys, &c.

2. SMALL-POX.—In certifying deaths from small-pox, the patient's condition with respect to vaccination should be carefully stated—say, in one or other of the following forms:—(1.) No evidence of vaccination. (2.) Vaccinated in infancy only—number of scars. (3.) Vaccinated only after infection by small-pox. (4.) Stated to have been vaccinated but no scars. [If the patient has been re-vaccinated, the date should be given when possible.]

3. MEASLES.—It is desirable that the use of the term "*Rubeola*" as a synonym for measles should be discontinued. "Morbilli" is the only Latin equivalent for this disease recognised by the Royal College of Physicians.

4. PUERPERAL FEVER AND OTHER SEPTIC DISEASES.—The term "*Puerperal fever*" should no longer be used. Pyæmia, septicæmia, or sapræmia occurring in puerperal women should be described as puerperal pyæmia, p. septicæmia or p. sapræmia respectively (Nomen: R.C.P., p. 11). In the new list of diseases provision exists for the separate entry of several forms of septic infection.

5. DIARRHŒA.—Attention is especially invited to a recent minute of the Royal College of Physicians advocating the use of authorised names for this malady. The minute runs as follows:—

> "The Royal College of Physicians is convinced, after careful enquiry: (*a*) that various unauthorized and misleading terms, such as '*gastro-enteritis*,' '*muco-enteritis*,' '*gastric catarrh*,' &c., are now commonly employed to designate the disease officially known as '*epidemic diarrhœa*,' whereby its specific character is in danger of being ignored, and great confusion ensues; (*b*) that the present confusion of terms renders it impossible to determine accurately either the prevalence of the disease in special places and at special times, the extent to which it influences the public health, or the effects produced by sanitary measures; (*c*) that there is a widespread objection, on the part of medical practitioners, to

the employment of the term '*diarrhœa*' in certifying the cause of death, probably because that term is generally held by the public to imply a mild disease, insufficient by itself to cause death.

"The College, therefore, has sought to discover as an alternative for the authorized term (epidemic diarrhœa) some other name, which, whilst equally accurate, should convey to the public the idea of a more serious affection. But the College regards it as essential that the idea of specificity, intended to be conveyed by the term 'epidemic' should be retained.

"As the result of much deliberation, the College has agreed to authorise the use of the term '*epidemic enteritis*' (or if preferred by the practitioner '*zymotic enteritis*') as a synonym for epidemic diarrhœa. The College has further decided to urge upon practitioners the entire disuse, in medical certificates of death, of such terms as '*gastro-enteritis*,' '*muco-enteritis*,' or '*gastric catarrh*,' as synonyms of epidemic diarrhœa."

6. MALIGNANT DISEASES.—Among cancerous affections "carcinoma" is now distinguished from "sarcoma." This distinction should be observed wherever possible, and the part of the body affected should be stated. A separate line is still retained for those forms of malignant disease the nature of which cannot be specified precisely.

7. TUBERCULOUS DISEASES. "*Phthisis.*"—When this condition is due to tubercle, the term "tuberculous phthisis" or "pulmonary tuberculosis" should be used instead of the ambiguous term *phthisis*, which is sometimes used to designate other besides tuberculous diseases of the lungs. "*Tabes mesenterica.*"—The use of this term to describe tuberculous disease of the peritoneum should be discontinued, as it is frequently used to denote various other wasting diseases which are not tuberculous. "Tuberculous peritonitis" is the better term to employ when the condition is due to tubercle. *Hydrocephalus.*—In certifying deaths thus caused, it would be advantageous if those due to tuberculous affections were distinguished from those due to meningitis or to other affections of the brain. "Congenital hydrocephalus" should always be returned as such.

8. CONVULSIONS.—It is hoped that this indefinite term will henceforth be restricted to those cases in which the true cause of convulsions cannot be ascertained. At present more than eleven per cent. of the total deaths of infants under one year are referred to "*convulsions*" simply.

9. PARALYSIS.—The classification of deaths would be much facilitated if brain paralysis were always distinguished from paraplegia. In certifying deaths from brain paralysis, the terms "*hemiplegia*" and "*apoplexy*," which denote symptoms merely, might usefully be replaced by the names or such definite lesions as "cerebral hæmorrhage," &c., &c.

10. PNEUMONIA.—Three separate forms of acute pneumonia have now been added to the list, viz:—Croupous or lobar pneumonia, broncho or lobular pneumonia, and epidemic pneumonia; the old term for undefined cases of pneumonia being still retained. The term "*typhoid pneumonia*" should never be employed, as it may mean either enteric fever, with pulmonary complications, on the one hand, or pneumonia, with so-called typhoid symptoms, on the other.

11. CROUP.—It were greatly to be wished that the use of the term "*Croup*" to designate non-diphtheric affections of the larynx or trachea should be abandoned. Diphtheritic croup or membranous croup should be returned as such.

12. CHILDBIRTH.—Whenever parturition or miscarriage has occurred within one month before the death of the patient, the fact should be certified, even though childbirth may not have contributed to the fatal issue.

13. VIOLENCE.—In every case of death by violence, or by suspected violence, the medical practitioner, in addition to stating the fact in his certificate, should advise the friends of the deceased to inform the coroner forthwith.

14. When the cause of death has been verified by a post-mortem examination, the letters P.M. should be added.

NEW LIST OF CAUSES OF DEATH as used in the Annual Reports of the Registrar-General for England and Wales.

N.B.—The terms printed in *italics*, being the names of symptoms merely, or being otherwise objectionable, should be used, in Medical Certificates, only when precise information is wanting.

GENERAL DISEASES.

Small-pox { Vaccinated. / Not Vaccinated. / Doubtful.

Cow-pox. Effects of Vaccination.
Chicken-pox.
Measles (Morbilli).
Epidemic Rose Rash, German Measles.
Scarlet Fever.
Typhus.
Plague.
Relapsing Fever.
Influenza.
Whooping Cough.
Mumps.
Diphtheria (*Membranous Croup*).
Cerebro Spinal Fever.
Simple Continued Fever.
Enteric Fever.
Asiatic Cholera.
Epidemic Diarrhœa, Epid. (or *Zym.*) Enteritis.
Diarrhœa, Choleraic Diarrhœa.
Dysentery.
Malarial Fever.
Hydrophobia.
Glanders, Farcy.
Anthrax, Splenic Fever.

Puerperal Septicæmia, Sapræmia.
Puerperal Pyæmia.
Phlegmasia Alba Dolens.
Puerperal Fever.
Infective Endocarditis.
Epidemic Pneumonia, Pneumonic Fever..
Erysipelas.
Septicæmia (not Puerperal).
Pyæmia (not Puerperal).
Phlegmon, Carbuncle (not Anthrax).
Phagedæna.
Other Septic Diseases.
Tuberculous Phthisis (Pulm. Tuberculosis).
"*Phthisis.*"
Tuberculous Meningitis.
Tuberculous Peritonitis.
Tabes Mesenterica.
Lupus.
Tubercle of other Organs.
General Tuberculosis.
Scrofula.
Parasitic Diseases.
Starvation.
Scurvy.
Alcoholism, Delirium Tremens.
Opium, Morphia Habit.
Ptomaine Poisoning.
Industrial Poisoning { by Lead. / by Phosphorus. / by Arsenic and other Metals.
Rheumatic Fever, Acute Rheumatism.
Rheumatism of Heart.
Chronic Rheumatism.
Rheumatic Arthritis, Rheumatic Gout.
Gout.
Carcinoma.
Sarcoma.
Malignant Disease, Cancer.
Rickets.
Purpura.
Hæmophilia, Hæmorrhagic Diathesis.
Anæmia, Leucocythæmia.
Diabetes Mellitus.
Premature Birth.
Congenital Defects.
Injury at Birth.
Atelectasis.
Want of Breast Milk.
Teething.
Tetanus.
Syphilis.
Gonorrhœa, Stricture of Urethra.

LOCAL DISEASES.

DIS. OF NERV. SYST.—
Meningitis, Inflammation of Brain.
Softening of Brain.
General Paralysis of Insane.
Insanity (not Puerperal).
Chorea.
Epilepsy.
Convulsions.
Laryngismus Stridulus.
Locomotor Ataxy.
Paraplegia and Disease of Cord.
Neuritis, Periph, Poly-Neuritis.
Brain Tumour (not specific).
Nervous System, other Diseases.

DIS. OF ORG. OF SP. SENSE.—
Otitis, Mastoid Disease.
Epistaxis, Nose Disease.
Ophthalmia, Eye Disease.

DIS. OF HEART.—
Valve Dis., Endocarditis (not Infective).
Pericarditis.
Hypertrophy of Heart.
Angina Pectoris.
Dilatation of Heart.
Fatty Degeneration of Heart.
Syncope, Heart Disease (not otherwise defined.

DIS. OF BLOOD VESSELS.—
Cerebral Hæmorrhage, Emb., Throm.
Apoplexy, Hemiplegia.
Aneurysm.
Senile Gangrene.
Embolism, Thrombosis (not Cerebral).
Phlebitis.
Varicose Veins.
Blood Vessels, other Diseases.

DIS. OF RESP. ORG.—
Laryngitis.
Membranous Laryngitis (not Diphtheritic).
Croup (not Spasmod. or Membr.).
Larynx, Disease of (not otherwise defined).
Bronchitis.
Lobar, Croupous-Pneumonia.
Broncho, Catarrhal, Lobular, Pneumonia.
Pneumonia (not otherwise defined).
Emphysema, Asthma.
Pleurisy.
Fibroid Disease of Lung.
Respiratory Diseases, other.

DIS. OF DIGEST. SYST.—
Tonsillitis, Quinsy.
Mouth, Pharynx, Disease (not specific).
Gastric Ulcer.
Gastric Catarrh.
Stomach, other Dis. (not Malig.).
Enteritis (not Epidemic).
Gastro-Enteritis.
Appendicitis, Perityphlitis.
Hernia.
Intestinal Obstruction.
Other Diseases of Intestines.
Peritonitis (not Puerperal).
Cirrhosis of Liver.

Liver and Gall Bladder, other Diseases.
Digestive System, other Diseases.

LYMPH., &c., DIS.—
Spleen Disease.
Lymph. System, other Diseases.
Thyroid Body Disease.
Supra Renal Capsules Disease.

DIS. OF URIN. SYST.—
Nephritis, Acute.
Chronic Bright's Disease, Albuminuria.
Calculus (not Biliary).
Bladder and Prostate Disease.
Urinary System, other Diseases.

DIS. OF GENER. SYST.—
Ovarian Tumour (not Malig.).
Other Diseases of Ovary.
Uterine Tumour (not Malig.).
Other Diseases of Uterus and Vagina.
Disorders of Menstruation.
Gener. and Mam. Orgs., other Diseases.

ACCIDENTS, CHILDBIRTH—
Abortion, Miscarriage.
Puerperal Mania.
Puerperal Convulsions,
Placenta Prævia, Flooding.
Other Accid. of Pregnancy and Childbirth.

JOINT DIS.—
Caries Necrosis.
Arthritis, Periostitis.
Other Diseases of Locomotor System.

SKIN DIS.—
Ulcer, Bedsore.
Eczema.
Pemphigus.
Skin Diseases, other.

Christmas Week.

NAAMAN CONCERT.

The concert in Naaman Ward took place on Monday, December 29th, at 6.30 p.m. The ward decorations were exceptionally pretty, long trails of ivy being festooned along the ceiling and round the windows and hung with numerous fairy lamps and Chinese lanterns. The programme was opened by Mr. G. A. Ticehurst with a pianoforte solo, played in his well-known style. Miss Florence Shee's powerful voice was heard to great advantage in "There is a Land," and a comic sketch by Mr. Ray Edridge was much appreciated. Mr. O. V. Payne received a hearty encore for "Varmer Jan," and responded with another of his characteristic dialect songs. A bassoon solo by Mr. K. Black caused much amusement, and was encored. Miss Ivy Kemsley gave a charming rendering of "If no one ever marries me," and as an encore "Cuckoo." Mr. Sanger delighted the audience by his two humorous songs. A violin solo by Mr. Cole was much enjoyed, as was also the singing of Mr. Felton and Mr. Harrison. A very pretty vocal duet was given by Miss *Nora Leyton* and Miss Ivy Kemsley. Three cheers for Sister Naaman and the House-Surgeon brought a most enjoyable entertainment to a close.

In Lighter Vein.

MANSION HOUSE APPEAL.

An urgent appeal for £300,000 has been issued to instal the Perriphone in the wards of Guy's Hospital.

The Early Morning Maggot has collected a symposium of incoherent and conflicting opinions which show that the trend of public opinion is undoubtedly that it should be removed to a suitable site in Hyde Park to afford amusement and work for the unemployed.

Colonel Pr-st-g declared it ought to be burned, but our reporter elicited that it would be of immense service if removed to the Nurses' Home.

S-st-r S-r-gy thought there was a swarm of bees inside it, and was confident the College Porter's name was Daisy.

Mr. T-r-tt thought something might be done by Vrrrson, or failing that, by some such instrument as a cephalotribe.

Mr. F-gg- thought it was a most remarkable case, and after attempting to remove some wax, remembered just such a case in Martha as a Ward Clerk, and another in Lydia as a Dresser, and yet another in the third bed beyond the fireplace round the corner near the dustbin, while H.S. to Mr. Lucas, and lastly on a scrap-heap outside the Clinique of Spitkoughsky in Berlin.

Mr. L-n- wondered why people used these elaborate instruments and thought a little sulphur well packed in for forty-eight hours would prevent the trouble.

Dr. F-c-tt thought there might be a minute perforation.

Dr. H- W- did not mind its removal if the Residents remembered nothing else in the lecture but that (firmly with both hands supinated and clenched) the perriphone was multiple, symmetrical, peripheral and an unmitigated nuisance, as it was *so* important.

Mr. L-c-s said when next in his bath he would examine the action of the supinator longus as influenced by the rotation.

Mr. F-nch said nothing (surprise and applause by the Clerks). Interviewed, he said he was

an obstetrician, and the isolation of Queen was splendid. For greater warmth he withdrew into a large hat.

Dr. B-y-nt had searched all the records and read Taylor through again without finding a similar case.

Mr. P-ll-n had left home two mornings ago to repair a slight breakdown and has not returned.

The engineer suggested he should be rung up when it had broken down, and escaped smiling.

Mr. Tu-hy said it ought to be "blacklisted" under the new Act for being so often speechless.

The H.P. broke into song:—

The telephone clattered and clashed and foamed
The bell crank whirred and rumbled,
And the listening sister shamed her ears
As she heard the following mumbled—

"Are you there? Do you hear? Are you there, oh—
I can't hear a word they say.
What? Wanted at once in Pat. and Sam.
Been ringing me all the day?

Just hurry up receiver, I want to get on
With Stephen. Oh! got you at last
Speak under. Can't hear me? I wonder what's wrong
No. 15 is *what*, Sister? Oh, ——.

Are you Mary? No, Daisy! What's wrong with you?
Who are you? I know hundreds of Daisies
Oh's the Matron's? Well speak up. What? Who's got the flu?
Oh shut it! Ring off! Go to blazes.

I've not had your message. What? Wanted in Queen,
Oh, somebody's ringing the bell.
I tell you the Charity hasn't been seen
I'm Atkins, John Atkins. Oh, —— well!!!

POLYPHONE.

Notice.

OBSTETRIC REGISTRAR AND TUTOR.

VACANCY.

There is a vacancy for the above appointment. Applications should be sent in to the Treasurer, the Superintendent's Office, Guy's Hospital, on or before Saturday, January 31st.

Duties of appointment to commence on Monday, February 9th.

Further particulars may be obtained of the Dean.

Sport.

Rugby Football.

GUY'S v. CATFORD BRIDGE.

Great interest was taken in this return fixture, played at Catford on Saturday, January 10th, as earlier in the season Guy's had been beaten on their own ground. A large and enthusiastic crowd witnessed one of the best contested games of the year. The weather was perfect and the ground in good condition. Milsom kicked off for the Hospital towards the Pavillion end. Play opened at half-way, but a well-judged kick by Harrison enabled Guy's to at once press. Catford relieved with a good forward rush, McEvedy saving well. Thus early it was evident a fast and exciting game would result, the Guy's three-quarters being in good form, and, with the forwards getting the ball out smartly, several bouts of excellent passing were witnessed. The defence of Catford, however, was very sound. O'Brien and McEvedy in turn essayed to drop goals, Catford touching down. Continuing to press hotly, the Hospital almost scored through Alcock, from a fine opening by Orpen, but he was pushed into touch in goal at the corner flag. The forwards were now playing with great dash, getting the ball repeatedly, and some excellent passing was displayed by the Guy's three-quarters. Weak tackling, however, resulted in Catford quickly transferring the seat of play to Guy's twenty-five, where Louisson saved well. Good kicking by Harrison and O'Brien brought temporary relief, but, owing to several kicks being charged down, a try by Catford seemed inevitable, when Layton, who was showing greatly improved form, saved brilliantly. A kick to Guy's for off-side, and sound play by O'Brien, Orpen and Brown relieved. Orpen was repeatedly conspicuous, and, after a good run, kicked across, but Alcock was well collared when looking dangerous. The game was now very fast, the ball travelling from end to end with great rapidity. Louisson saved well, and a good tackle by Harrison averted danger. Glendinning came away with a fine dribble, and faultless passing by Guy's behinds should have resulted in a try. McEvedy immediately afterwards dropped a fine goal, the ball unfortunately touching an opponent in its flight. From an opening by O'Brien, Brown made a strong run into Catford's twenty-five. Half-time:—

Guy's ...	...	Nil.
Catford Bridge	...	Nil.

On resuming, play at once became exciting. The forwards, wheeling the scrum in great form, rushed the ball half the length of the field; Saunders, Ward, and Thompson being conspicuous, and with the aid of O'Brien and McEvedy Guy's immediately attacked. Pinching showed good form from the line out, and McEvedy gained ground with a good kick. Again, however, weak defensive

work permitted the Catford forwards to break through, and for a time the hospital goal line was hotly attacked. Harrison, from a mark, relieved with a beautiful kick, a feat again accomplished shortly afterwards. Alcock twice looked dangerous from openings by O'Brien. A little later McEvedy, who was playing a good game, passed out to Orpen, who, after a fine effort, scored far out. Harrison's kick just fell short.

The rest of the game continued to be full of interest, each side in turn attacking. Some excellent tackling by Brown and Louisson followed. The forwards displayed considerable skill. Pinching, Saunders, and Glendining, leading a good rush, led to McEvedy looking dangerous. After O'Brien had gained much ground from a kick for off side, no side sounded leaving the score—

Guy's	1 try (3 points)
Catford Bridge	Nil.

TEAM:—GUY'S—E. M. Harrison (back); F. Alcock. P. F. McEvedy, L. J. J. Orpen, H. S. Brown (three-quarter backs): A. B. O'Brien, M. G. Louisson (half-backs); R. G. Anderson, B. Glendinning, E. L. Ward, A. R. Thompson, E. H. B. Milsom, W. G. Pinching, S. M. Saunders, T. B. Layton. Referee, Mr. Gardiner. Linesman, Mr. E. Morgan.

REMARKS.—Harrison's fielding and kicking repeatedly called forth applause. Orpen was in great form, although at times inclined to run across too much. Layton showed marked improvement.

DRAW FOR INTER-HOSPITAL RUGBY CUP.

1st Round	2nd Round	3rd Round
Middlesex, Guy's — Jan. 27th	Feb. 10th	Feb. 26th
St. George's, St. Bart.'s — Jan. 22nd		
St. Mary's, St. Thomas — Jan. 29th	Feb. 12th	
University Coll.		
Charing Cross, Westminster	Feb. 3rd	Feb. 24th
London, King's College	Feb. 11th	

The Final to be played on March 4th.

Hobis Food.

This was tried on three babies, two from the start and one after humanised milk had been used. They were all three Cæsarian section babies, and the results were very good, and the mothers are determined to feed their babies on the food for the future.

The only drawback we can find, such as it is, is a tendency to constipation and the expense of the food. There can be no question but that the babies like it and that it suits well in London where pure milk is not often seen.

Appointments.

MILITARY.

Colonel G. C. HALL, Bengal Establishment, is permitted to retire from November 1st. He was appointed Assistant Surgeon, 30th March, 1872, and became Colonel in December, 1901.

Lieutenant-Colonel J. DUKE, Bengal Establishment, is also permitted to retire from November 1st. His first commission bears date 30th March, 1872, that of Brigade-Surgeon-Lieutenant-Colonel, April 2nd, 1898. He was in the Afghan War, 1878–80, including the action of Charasiah, the operations at Kabul in December, 1879; the march from Kabul to Candahar, and the battle of September 1st. He was also with the Mari Expedition (mentioned in despatches, meda with three clasps, and bronze decoration.)

Pass List.

University of Cambridge, Michaelmas Term, 1902.

THIRD EXAMINATION FOR THE MEDICAL AND SURGICAL DEGREES.

PART I.—H. Acroyd, J. H. Donnell, J. Goss, W. M. Mollison, C. M. Murray.

PART II.—H. Davies-Colley, M. C. Hayward, C. R. Howard, F. H. Parker, H. Wacher, J. A. Wood.

SECOND EXAMINATION.

F. D. Crew.

Papers by Guy's Men.

Case of Volvulus of the Cæcum. By F. R. B. Bisshopp, M.D. With Notes on the Operation by Alfred D. Fripp, C.V.O., C.B., M.S., F.R.C.S.—*British Medical Journal*, 10th January.

Intravascular Antisepsis. By J. M. Fortescue-Brickdale, M.A., M.B., B.Ch. Oxon. (From the Bacteriological Department, Jenner Institute of Preventitive Medicine.—*The Lancet*, 10th January.

Birth.

WAKEFIELD.—On January 7th, at Lincoln Lodge, Horley, Surrey, the wife of Christopher Frank Wakefield, M.R.C.S., L.R.C.P., of a daughter.

Death.

MARSHALL.—On December 24th, at 143, Grange Road, Bermondsey, John Marshall, M.R.C.S. Eng., L.S.A. Lond., aged 57.

ED.—J. M. B.

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Notice.

All Communications, Articles, Letters, Notices, and Books or Review, should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, SECRETARY'S OFFICE, GUY'S HOSPITAL.

The charge for binding in blue, with the Arms o the Hospital in gold will be ONE SHILLING AND SIXPENCE.

Calendar of Coming Events.

Jan., 1903.

Sat. 31.—Messrs. Symonds and Steward's take-in; Drs., G. C. F. Robinson and G. H Rees; Cl., H. S. Brown.
1 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., I., R.I.E.C., away.
II., Epsom College, away.
IV., Wasps IV., away.
G.H.A.F.C., I., Cheshunt, home.
II., Cheshunt II., away.

Feb.

Mon. 2.—1.15 p.m., Clinical lecture by Dr. Horrocks.

Tues. 3.—Inter-Hospital Rugby Cup Match, 2nd round. Charing Cross v. Westminster.

Wed. 4.—1.30 p.m., Clinical lecture by Mr. Jacobson.
G.H.R.F.C., I., Oxford University, away.
II., R.I.E.C., II., away.
III., Dulwich College, II., away.

Thur. 5.—Messrs. Lucas and Lane's take-in; Drs., E. C. Lowe and W. S. Orton; Cl., E. Faulks.
Inter-Hospital Rugby Cup Match, 2nd round. London v. Kings.

Fri. 6.—Test Exams. for Revision Classes for Final L.D.S. Eng., begin.

Sat. 7.—1 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., I., Kensington, home.
II., Kensington II., away.
G.H.A.F.C., I., Ewell, home.
II., Ewell II., away.

Mon. 9.—1.15 p.m., Clinical lecture by Mr. Brailey.

Tues. 10.—Inter-Hospital Rugby Cup Match, 2nd round. Guy's v. St. Bartholomew's.

Wed. 11.—1.30 p.m., Clinical lecture by Mr. Jacobson.
G.H.P.P.S., Paper, "Post Operative Treatment." By J. M. Brydone.
G.H.R.F.C., III., Merchant Taylor's School, II., away.

Thur. 12.—Messrs. Golding-Bird and Dunn's take-in; Drs., C. J. S. Dismorr and D. H. Richards; Cl., T. Morland Smith.
Inter-Hospital Rugby Cup Match, 2nd round. St. Thomas' v. University.

Sat. 14.—1 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., I., Lennox, home.
II., Lennox II., away.
III., Wasps, III., away.
IV., Dulwich III., away.
G.H.A.F.C., I., Reigate Priory, away.
II., Surbiton Hill, 2nd XI., home.

Guy's Hospital Gazette,

JANUARY 31, 1903.

A Case of General Tuberculosis.

CLINICAL LECTURE BY DR. HALE WHITE.

June 11th, 1902.

(*For the report of this lecture we are indebted to the* PHILADELPHIA MEDICAL JOURNAL.)

GENTLEMEN,—Some of you may be able to call to mind the post-mortem which was made about ten days ago on a little boy, five years old, who had come from John Ward. If you do, you will remember that he presented gray tubercles about the size of a small shot in very many parts of the body. The lungs were quite stuffed with them, and there must have been thousands of them there; you could see them on the pleura, and you could actually see them on the surface of the heart, which is a very rare situation. Coming to the abdomen, there were plenty of them on the peritoneum. You could see them in the liver, you could see them in the kidneys, you could see them in the spleen. And then, going up to the skull, you could see numbers of them in the brain, or rather in the pia mater, running along the vessels. And this afternoon I thought we would go over such a case as this, for unfortunately they are very common. Now I have not told the whole that was found at the post-mortem examination, for in addition to these grey tubercles scattered so

widely over the body, there was a considerably enlarged caseating bronchial gland. It was softening in the middle, and all the evidence there is goes to show that what happened to that child was that this caseating bronchial gland had been there for some time, that it broke down and from it the whole of the body was, by means of the blood, flooded with a number of tubercle bacilli, and these, getting deposited in various parts of the body, formed the little gray nodules that I have told you were found in so many organs. That being so, it is clear that the first thing in thinking over a case like this, which we have to consider is—How did the child get this trouble? How did that bronchial gland become caseous? You may say, "Oh, it became caseous because there were plenty of tubercle bacilli in it. That is perfectly true, but we must go back a step further and see why the tubercle bacilli came there. A few years ago great stress would have been laid in a case like this upon the importance of heredity. A person who was born of a strongly tuberculous stock was looked upon as almost doomed, and in a case like this the child's ancestry, both direct and collateral, would have been ransacked in order to try to discover whether any of his relations were tubercular; and, if any of them had been found to have suffered from consumption, there would have been satisfaction, for the opinion of the time would have been satisfied; the whole trouble would have been regarded as hereditary. But it is clear that, when the tubercle bacillus was discovered, the question had necessarily to be re-investigated, because we know now that you can have no tubercular disease without the presence of the tubercle bacillus. And there are clearly, in such a case as this, two possibilities.

In the first place, it has been suggested that tubercle bacilli may pass directly from the parent and affect the ovum, and in that way tubercle is hereditary. Now, if the tubercle bacillus is going to be directly transmitted from the parent to the child, obviously there are two possibilities, namely, that it may be transmitted either from the male parent or from the female parent. And in the case of transmission from the male parent it is necessary that the ovum itself should get affected without first of all giving tubercular disease to the female. It is a difficult question, which can only be settled experimentally, whether the male can directly cause tuberculosis in the fœtus. Friedmann has performed a number of experiments in this direction on rabbits. His results have not been confirmed, but as far as they go they show that such a thing is possible. But clinically it is of very little importance, because this much appears quite clear, that, unless there is tubercular disease of the male organs of generation tubercle bacilli cannot be transmitted from the male to the fœtus. And you will see easily that in the first place tubercular disease of the male organs of generation is not, after all, so very common, and many of those unfortunate people who suffer from it are far too feeble to become the parents of children. So we may dismiss from our minds the question of whether the bacilli have been directly transmitted from the father to the child, as it is not of clinical importance.

The next thing, which is much more important, is: Can tubercle bacilli be transmitted directly from the mother to the offspring? Naturally, before answering that question, you would say, What is the experience of cattle breeders? For they should know. A good deal of work has been done in that direction, and here I have some figures. Some of the best are those of Bang, of Denmark. He took all the young calves in a herd of 208 and injected them with tuberculin and found that only two of those calves were tubercular, and those very slightly. MacFadyean, an English investigator, puts the proportion of calves born tuberculous at not more than one to three per thousand. So, from the animal point of view, the transmission of tubercle directly to the fœtus is very rare. But you must be very cautious of immediately transferring those results to man, because we do know that tubercle bacilli behave differently in different animals. For example, guinea-pigs are particularly susceptible to tubercle bacilli. On the other hand, the tubercle bacilli hardly affect goats at all. In birds tubercle bacilli

behave in a peculiar way. To keep to the case of animals for a moment, it has been shown directly that susceptible animals may be born with tubercle bacilli in them. One experimenter (among others), named D'Arrigo, has shown that guinea-pigs born of tuberculous mothers may be found stuffed with tubercle, even immediately after birth. So in a susceptible animal like this, it is clearly possible for bacilli to be transmitted directly from mother to fœtus. However, to return to man, some of you here may remember that last October we were very interested ourselves in the question, because a woman in No. 15 bed in Mary ward was pregnant and also was very severely affected with phthisis. There are in men several instances on record in which tubercular mothers have given birth to fœtuses that had a good deal of tubercular disease in them, and, as you would expect, owing to the blood from the umbilicus going straight to it, the liver is the first organ affected and is found full of tubercle bacilli. In a case like that in Mary, tubercle bacilli have been recovered from the blood in the umbilical vein. I have read of many cases in which tubercle bacilli have been found in the fœtus when the mother has been tubercular, and they have been found so shortly after birth that it could not be a question of infection after birth. But, although I have read of many, it is only because I have happened to be particularly interested in the subject when the woman to whom I have referred was in Mary ward some time ago. But the cases are really very few, remarkably few, considering the number of phthisical mothers. At that time I brought to the ward an account of a French case and lent one of you the journal containing the account, because it was the best case that I could find. Since then a book on fœtal pathology, by Ballantine, has been published, and he quotes the same case that I brought to you. I think, therefore, we may take it as a very fairly typical case. It was the case of a mother who died four days after her confinement. In the mother the lungs, liver, the spleen, the intestines, mesenteric glands and kidneys were tubercular. The genital organs were healthy. The fœtus lived twenty-six days, and in the fœtus, the liver, the spleen, the lungs, the bronchial glands, the heart and the placenta were all tubercular, and animals injected with the fœtal organs and part of the placenta and blood from the umbilical vein all died of tuberculosis. There are a few cases on record in which, although the fœtus contained no naked-eye tubercular lesions, yet tubercle bacilli were found in it and also bacilli in the fœtal blood. But I have mentioned these cases to you as a matter of curiosity, in order that you should know exactly how our knowledge stands. But please remember they are very rare, because, although they are just the sort of cases which would be recorded, only five or six have been placed on record within ten or twelve years. And you will all get impressed with their rarity if you think of that case in Mary ward. Because, although the mother was riddled with tubercle, the placenta was found to be healthy, and thus you learn that, even when the mother is very badly affected with tubercle, direct transmission to the fœtus is very rare indeed. Again, you have to remember, as bearing on this, that usually the mother herself is so ill that it is hardly likely she will bear many children. What I have been telling you about the great rarity of direct transmission from the mother to the child is borne out by the fact that there are few children who have tubercle very early in infancy. That is an important practical point to bear in mind. Infants a few weeks old are rarely found affected with tubercle. For instance, Lartigau, quoting from Fröbelius, says he found tubercular disease in only 416 infants out of 18,569 dying at ages varying between one and four months. That is very striking, and statistics compiled by other authors show the same facts. It is a very practical point for you to remember in medicine that tubercular disease in children a few months old is rare, and even in the few cases in which it occurs you must not be carried away with the notion that it necessarily means tubercle was directly transmitted from the mother to the fœtus, because cases are often found among the poor in which the child during the first few months of life lives in ill-ventilated rooms, in which it is only too likely to inhale the tubercle bacilli from the mother's expectoration.

The sum total of all I have told you is that the direct transmission of tubercle bacilli from the male or female parent to the fœtus is so rare that it becomes a mere curiosity, and you can dismiss it from your minds at once as of no practical clinical importance. And that is a matter of great moment for you to remember, because you are often asked the question point blank in practice whether such direct transmission is likely to occur.

Not only is it possible that the tubercle bacilli should pass directly from the mother to the fœtus, but a second possibility occurs to you, you say tubercle bacilli themselves do not pass, but something is transmitted—a weakness or a lowered resistance, or something of that sort—from the parent to the child, in virtue of which the child very easily becomes tubercular, having a low resistance to a fortuitous invasion by tubercle bacilli. This again is a question constantly turning up for you in practice. You will be asked about it in regard to marriage, and almost every day of your life in regard to insurance, if you do any life insurance work.

Therefore we have next to consider: Is there transmitted from parent to children a deficiency in resisting power to invasions of tubercle bacilli? Is there something transmitted comparable, for instance, to the transmission of epilepsy or insanity? With regard to that, before you begin to think about it, please be very cautious what you read. I hardly know of any paper or collection of figures on the subject which are worth much, because the fallacies in the evidence are so numerous; for instance, you have only, generally speaking, the person's word for it that the parents were tubercular. Supposing a man is tubercular and is cured when young, what likelihood is there that a son, say at thirty-five years of age, will know that his father was tubercular and that he had been cured of it? Another fallacy is that very often these diseases are called by incorrect names. Phthisis is called pneumonia, and sometimes it is called bronchitis, sometimes with the intention of deceiving, sometimes from ignorance. Again, many a case, as Professor Tyndall showed in the *Nineteenth Century*, many a case which appears hereditary is one of direct infection, because the child is brought up in a stuffy and ill-ventilated cottage and is associated with parents who are tubercular. There are some excellent cases in point published with regard to the cottagers of Scotland by Dr. Clifford Beale. Professor Tyndall's were taken from the Swiss cottages. In country cottages which are stuffy and ill-ventilated the mortality is often as great as it is in big towns. Another fallacy is that tubercular people are often weak and the mother will be found unable to nourish her child well, either before or after birth. Again, these people are generally inefficient bread-winners and therefore they are unable to provide proper food for the child. These are only some of many fallacies, so the difficulties are enormous in dealing with collections of figures bearing on the point. But the difficulties are not only those of evidence, but of reasoning. People go to a hospital like that of Brompton and say that they find such and such a percentage of people in Brompton Hospital have consumptive parents. Well, that evidence is not worth writing down unless they also bring forward the number of people there are in the world who are not at Brompton and yet have consumptive parents. The best publication which I am aware of that deals with the matter in a reasonable way is one by Mr. Manley, who is actuary to the Mutual Life Insurance Society. The result he gives is this: If you insure people who at the time that they propose to insure are apparently perfectly well, but who give a tubercular history in one or both parents, you must add about five years to their age, to counteract the tendency that they have to a shorter expectation of life than the normal. The people from whom these results are deduced are apparently perfectly well at the time the proposal is made, and careful physical examination and enquiry into the history fails to detect any evidence of tubercle in them. These figures clearly show that there is probably something inherited which makes the child of tubercular parents, even though it is apparently healthy, to have a less expectation of life than the normal. It does not prove exactly what we want to know, you will notice, because it only proves that the expectancy of life in persons with tubercular parents is less than it should be; but we do not know that all

these persons with tubercular parents will die of tuberculosis. Mr. Manley's statistics do not go as far as that; they only show that the expectation of life is less. It is true there is an offset to that, namely, that the figures appear greatly to understate the probability that a direct inability to resist tubercle bacilli is inherited, because they take no account of the people who, having inherited this lowered resistance, die of tuberculosis before they come to insure their lives.

Please do not think this discussion has been mere waste of time: it has not. And let me sum up by stating once more, because you will always be asked about it, there is no evidence that direct transmission of bacilli from parent to offspring is otherwise than so rare that you may set it aside; but there is distinct evidence that there is transmitted from the parent to the child a lowered resistance, in virtue of which the expectation of life is less in those of tubercular ancestry than those who have not such an ancestry. I might mention that Dr. Claud Muirhead has lately analyzed the figures of the Scottish Widows' Association, and he comes to much the same result.

Now, to go back to our child, we may conclude with regard to that child that it is quite possible the child inherited some lowered resistance to tubercle bacilli. You will say:—You have not told us how the tubercle bacilli get in. The tubercle bacilli, we believe, either get in by inhalation or by the food, and the inhalation we will leave for the moment and consider the possibility of the child having got its tubercle bacilli by means of the food. That is a point of great practical importance to you. Parents will begin talking to you about it directly you get into practice. In the first place, again let me impress upon you the importance of bearing in mind the fact that tubercle bacilli in different animals differ in their behaviour, just as various races of mankind differ from each other. You know that tubercle bacilli in birds will flourish when you introduce them into other birds, but not when you introduce them into mammals. Then, again, let me quote to you this experiment: Carp were injected with the sputum of tubercular patients, and nodules developed upon the carp. Tubercle bacilli taken from those nodules were injected into guinea-pigs, and the guinea-pigs were not very much the worse for it. If the tubercle bacilli had been injected straight into the guinea-pigs, they would have been killed, for there are no animals more easily killed by tubercle. So the passage of tubercle bacilli through the fish greatly modified them. Again, even different breeds of swine, but of the same species, are found to react to tubercle bacilli differently. So it will be, in what I am going to tell you now, very important for you to remember that the same bacillus behaves very differently in different animals, and therefore you must be very cautious in transferring to man the results of experiments on animals. Until last summer it was accepted all the world over, I think, so much accepted that you would have been looked upon as a heretic if you attempted to doubt it, that tubercle bacilli from cattle can infect human beings; and it was not until Koch gave his celebrated address on the subject that any doubt was raised in the matter, at any rate in the mind of the profession and the public, although it is only fair to say some had doubted it, but they were men who were crying in the wilderness. Koch said he believed that tubercle bacilli derived from cattle could not infect man, at any rate through the food. The matter is clearly of the very greatest importance, because milk drawn from cows with tuberculous udders may swarm with tubercle bacilli. Please remember that it is of no use in this argument to bring forward any cases in which milk containing tubercle bacilli has caused tuberculosis in guinea-pigs. We must keep to man, for the reasons I have given you, namely, tubercle bacilli behave so differently in different species. Koch's reasons were these: His first argument was that he could not induce tuberculosis in cows by means of tuberculous human sputum, and he said, though that was not proof, that it was suggestive that the converse would be true, namely, that tuberculosis in human beings could not be induced from cows. He performed the following experiments. He took nineteen healthy cattle and introduced human tubercle bacilli into them, sometimes by swallowing, sometimes by injection. The cattle

were killed a sufficient while afterward, but in no case had the human tubercle bacilli flourished in them or produced tubercular disease. He fed six young swine for three months on tubercular sputum, but the animals remained healthy and grew lustily. At the end of three and a half months they were killed, and no traces of tubercular disease could be discovered in them. Other people have done similar experiments and and some have confirmed Koch's results; and when the results have not been confirmed, it is often probable that the infection was a mixed and not a pure one. So from these experiments the contention is that, if tubercle cannot be directly transmitted from man to cows, it is unlikely that tuberculosis can be directly transmitted from cows to man. You will say that it is only unlikely, but have you any direct proof that tuberculosis cannot be transmitted from cows to man? The first thing is to take the case of wounds. There is a case on record of a butcher, who, when slaughtering a tuberculous animal, cut himself, and he developed tuberculosis in the wound. But remember that the number of instances pointing in the other direction are very great indeed. For example, at the time that carcinoma and tuberculosis were thought to be antagonistic, a number of subjects of carcinoma in Germany were injected with tubercular matter, but no tuberculosis occurred in them. Again, there is the case of a veterinary surgeon who was aspirating a tubercular abscess in an animal; the animal lurched at the time and the syringe of tubercular matter went into the surgeon's hand, but the man developed no tuberculosis. And the whole evidence is to the effect that direct transmission by wounds is so rare as to be a mere curiosity. Another important point for you to remember is that, if tuberculosis were transmitted by milk, we should expect to get great epidemics of tuberculosis, especially in children. Everybody knows that we have had epidemics of scarlet fever disseminated by means of milk, and epidemics of diphtheria and of typhoid propagated in the same way, and one has been able to name the particular dairy from which the mischief arose and to trace the people who have had milk from that dairy and who were affected. But there is no such epidemic on record with regard to milk and tuberculosis. If what was thought to be true is true, namely, that tuberculous milk causes tuberculosis in children, we should expect to have plenty of epidemics reported by medical officers of health; we should hear of hundreds of children in a particular locality dying who had milk from a particular dairy, but no such cases are forthcoming.

Another argument is: Supposing tuberculosis were directly transmitted by milk to children, we ought, in post-mortems on infants, to find primary tuberculosis of the intestine and mesenteric glands very common indeed. Let us examine and see if that is so. Koch says that it is not so. He says he has only seen in young children primary gastro-intestinal tuberculosis twice in his life. Again, he says among a great many post-mortems performed on children at the Charité Hospital at Berlin there were only ten cases of primary tuberculosis of the bowel in five years. Again, among 3,104 post-mortem examinations on tuberculous children, Biedert only found sixteen cases in which it was primarily of the intestinal tract. Dr. Still who used to be here, but is now at Great Ormond Street Children's Hospital, has gone carefully into the question, and I will write upon the board figures which he obtained. The question which he wanted to solve was this: Was primary tuberculosis of the gastro-intestinal tract particularly common in young children, as one would expect it to be if tubercular milk gives rise to gastro-intestinal tuberculosis? His figures were as follows, and he contrasts the number of deaths in post-mortem work from the respiratory system with the deaths in which the trouble was in the gastro-intestinal tract. Here are his figures:

	Primarily Respiratory.	Primarily Intestinal.
Under 6 months the proportion was	10	None
6 to 12 ,,	22	5
1 to 2 years	44	15
2 to 3 ,,	21	6
3 to 4 ,,	21	11
4 to 5 ,,	12	2
5 to 6 ,,	9	7
6 to 7 ,,	4	7
7 to 8 ,,	3	3

Look and see what those figures teach us. They show that at the very age when the child is fed exclusively upon milk the proportion of gastro-intestinal primary tuberculosis to pulmonary primary tuberculosis is actually less than when it takes other food. So those figures, to my mind, are very strong evidence in considering this argument, that the child does not, at any rate, commonly get infected with tuberculosis by the use of tuberculous milk. My own impression, derived from the post-mortem room, certainly is that primary gastro-intestinal tuberculosis in children is comparatively uncommon, and you will remember that in the child whose case we are considering the intestine and mesenteric glands were quite healthy. Lately it has been said that, after all, even if tuberculous milk does not cause primary gastro-intestinal tuberculosis, it causes tuberculosis of the tonsils, but it is as likely that infection should take place in the tonsils by the air breathed as by the food taken. You will say: Why is there such a fuss throughout the country about this question of tuberculous milk? The reason is this: In the first place, everybody had the belief that tuberculous milk caused many cases of tuberculosis in infants, because they thought it was probable, and so they did not stop to inquire whether it was true. There is a further reason, and it is here in the statistics published by Dr. Tatham and Sir Richard Thorne-Thorne; they say in the last forty-five years there has been a reduction of 27·9 per cent. of deaths from all forms of tuberculosis. In phthisis the reduction is 66 per cent., while the corresponding reduction in tabes mesenterica was only 3 per cent. From this it is correctly concluded that the frequency and fatality of tabes mesenterica is not declining as rapidly as the rest of the forms of tuberculosis, and this is thought to be because we have improved our general sanitary conditions, and so phthisis, which is due to infection by the respiratory tract, is less common. But, it is said, look how tabes mesenterica still remains at a very high number. Why? Because, the argument runs, children are fed upon tubercular milk. But the fallacy of the whole thing is obvious. These figures were drawn from death certificates. There is not one post-mortem in a thousand of the children who die, and when the doctor is not sure what may be the cause of death he often says that it is from tabes mesenterica. The moment these figures were published, Dr. Still and Dr. Wills and Dr. Carr brought forward figures to show that primary gastro-intestinal tuberculosis, as verified by post-mortem examination, was by no means a common cause of death in young children at the time when they are fed upon milk, and there is no doubt that it is a grave error to assume that the tabes mesenterica of a death certificate means tuberculosis. Goodness only knows what it does mean in many cases, but it certainly rarely corresponds to primary gastro-intestinal tuberculosis. You may say: How does this bear upon the case which is the subject of this clinical lecture? I want to urge upon you that probably this child did not get its infection through its gastro-intestinal tract. If you will go back to the account of the post-mortem you will find that the child had an old caseous bronchial gland and that its gastro-intestinal tract and all its mesenteric glands were free from tuberculosis, and therefore the primary infection was not gastro-intestinal but respiratory. Do not go away with the impression that I am arguing that you should use tubercular cows from which to draw your milk supply; our object this afternoon has been to get at the truth and see whether food is a common cause of infection. The truth, I believe, is that it is an uncommon cause. Nevertheless, I should much prefer to know there were no tubercle bacilli in the milk upon which the child was fed, for there is no evidence to show that milk is never a cause of infection.

So much for the way in which this child got its tuberculosis. Most likely it was not by food; it was probably, therefore, by inhalation, and the fact that it was the bronchial gland which was affected confirms this.

Now for some clinical symptoms shown by this child. I told you that at the post-mortem examination it was crammed with miliary tubercles in most parts of its body. In many parts of the body the presence of miliary tubercles does not give rise to symptoms, and,

whatever part of the body you are considering, you must, clinically, always draw a very sharp line between chronic and acute tuberculosis. For instance, this child had a number of little tubercles scattered about in its kidney. As far as we know, acute miliary tubercles there give rise to no symptoms, but you know that a chronic caseating kidney gives rise to pyuria, pyrexia and other serious symptoms. Or, take the peritoneum, you know that acute miliary tubercles scattered about in the peritoneum, such as were present here, frequently give rise to no symptoms during life and, if they do, usually they are quite overshadowed by the greater importance of the symptoms owing to the affections of the lungs or meninges. But, on the other hand, chronic tuberculosis of the peritoneum leads to caseation and fibrous adhesions and many things of that sort, which cause great lumps in the abdomen and altogether make a very striking case. Again, take the heart. Tuberculous pericarditis is a definite, though rare, rather chronic disease. But acute miliary tuberculosis of the pericardium gives rise to no symptoms.

You may say, What are the parts of the body that I can look to to give me evidence by which I can diagnose this acute condition? I do not think you can diagnose it ordinarily in any other parts of the body than in the lungs and in the brain. It is true that the books describe a form of tubercular peritonitis in which not many nodules are found in the peritoneum, but a quantity of ascitic fluid; but my experience is that in such cases the symptoms of peritonitis are overshadowed by the symptoms in the lungs and brain. And, for practical purposes, I do not think you can diagnose acute miliary tuberculosis in any other situations in the body than in the brain, lungs, and choroid. First of all, let us take the lungs, and I do hope I can now give you a picture of what happens, because these cases in which the diseased lungs are giving rise to symptoms, are so frequently overlooked. In the first place, you must dissociate what we are going to talk about from phthisis. In phthisis there are physical signs which are nearly always most marked at the apex of the lungs. In acute miliary tuberculosis of the lung the disease is not confined to any part of the lungs; it is scattered all over them; there are hundreds and thousands of little tubercles scattered and disseminated all over the lungs by the blood coming from the primary focus. In this child the primary focus was a bronchial gland. In chronic phthisis the tubercle bacilli get into the lungs because they are inhaled, and they settle into the apex. In acute miliary tuberculosis they get into the lung by the blood and become diffused all over it. I grant that there may be intermediate cases, but we cannot, from lack of time, go into that now. Nearly always in this acute miliary tuberculosis of the lung the patient is dead long before the tubercles have time to caseate or to form fibrous tissue. When you are face to face with a patient like this, if there is no meningitis to help your diagnosis, this problem comes before you: There is a patient obviously very ill, as I know by the fact that the temperature is ranging high and the pulse is very rapid. I have been over the body very carefully, but I cannot find any physical signs to account for the condition. Such patients lie in the hospital here day after day and get into their second and third week, but still the problem remains, What can be the cause of the pyrexia? You say, I have nothing before me but a patient obviously ill, with a high temperature and rapid pulse, and it is often a very rapid pulse. The first indication of what is at the bottom of the trouble is usually to be found in an increasing rapidity of respiration; the respirations become more rapid than the rise in temperature would lead you to expect. Well, directly that occurs you should begin to ask yourself whether you have not a case of acute miliary tuberculosis of the lungs. Then the next thing which strikes you is that the patient is getting a little dusky about the cheeks and you find a little lividity about the lips. You look at the finger-nails and find that they are a trifle livid, too. That, to a practised eye, is almost proof, met in such a patient as this, that you are dealing with one who is suffering from acute miliary tuberculosis of the lungs; and often these patients die without any further evidence being forthcoming until sometimes just a short

time before the end. In fact, occasionally no further evidence of the cause of the illness is forthcoming, but usually you discover a few physical signs in the lungs and these signs generally are a little fine crepitation here and there, not necessarily at the apex. The report tells us that this was all that was found in the lungs in this case, and even that was not observed until a few days before the death of the patient. Usually there is no abnormality in the percussion note or voice sounds. In children there may be a little dulness owing to collapse of the lung in between the tubercles. Expectoration is often completely absent, partly because the tubercles are not affecting the bronchial mucous membrane and are not setting up bronchitis. Be the cause whatever it may, the clinical fact to be remembered is that these patients often have no expectoration; even when there is, it is only bronchitic expectoration, and there may be no bacilli discernible in it. Sometimes these patients bring up a little blood, but that is rare. They get weaker and weaker, the temperature remains high, the pulse remains rapid, and as they get weaker they sweat. There are the general signs of fever, such as a trace of albumin or a furred tongue, and if the lividity is great there may be a trifling swelling of the feet, but nothing to be of much value to you. The feebleness increases and the patients are often dead in four to six weeks from the commencement of the illness. It is a condition which may occur at any age, but, inasmuch as it is often associated with meningitis, it is most common in children.

You may say: Can this disease, acute miliary tuberculosis of the lungs, be mistaken for anything? Generally speaking, for the first weeks you cannot make up your mind what is the matter with the patient, who is usually suspected to be affected with typhoid fever. Later on physical signs appear, and the case is then often mistaken for acute bronchitis. But with a little care I think that should be avoided. What leads to the error is that sometimes this condition of acute miliary tuberculosis develops in lungs which are already emphysematous. The disease is uniformly fatal, and what I have described to you are just the symptoms which you might expect in a typical case, and the disease in the lungs would have carried off the child we are discussing if it had not died from its tubercular meningitis. With regard to tubercular meningitis, I do not propose to go over all the points of it, because I have already given you a lecture on the subject this year, and it would take so long now. But I will proceed to direct your attention to a few particular points about this case.

When the child came in the mother said it had a cough, which is suggestive that these patients do have a cough very frequently Then one of the first things which interested us in the case was that the mother said the child had had an ear discharge. The report on the case is a very long one, but the striking facts about it, when the patient first came in, were that there was some right facial paralysis involving the lower part of the face, and the tongue deviated to the right; the left leg was weak, but the extraordinary part of the case was that all these symptoms passed off within a week of the child's admission. This fact made the diagnosis very obscure indeed. I took the case on after those symptoms had passed off, and when I saw the patient the striking symptoms were these: On the 21st of May we noticed that the pulse had been getting slower and somewhat irregular, and we also noticed on the next day that the pulse was still slower and irregular, that the patient was very drowsy and had a slow way of responding to anything that was said to it, a kind of slow cerebration. If the patient had been older that symptom would have been more striking. In older people in this state, if you ask a question, the patient will apparently drop asleep again before answering it. The child lay there in bed very drowsy, its pulse was getting slower, and the whole condition, from the symptoms, was very suggestive of cerebral abscess, especially as the temperature was only a little raised. No child should die of cerebral abscess, especially as in this case there was a history of ear discharge which might have caused the abscess. It is a disease which certainly ought to recover after operation. We knew pretty well that it was not a case of thrombosis of the

sinuses secondary to ear trouble, but we thought the disease might be an abscess, but we were not sure. We had before us the possibility of its being meningitis, but, if it were, nothing could be done to save the child's life. But if it were abscess, it might be saved, and, reasoning in this way, I asked Mr. Dunn to see it. He trephined and made search for the abscess, but without success. That being so, the diagnosis of meningitis became certain and later on confirmatory signs developed. But even then I was not quite on the right track about the case; because with the history of ear discharge I was inclined to think the meningitis was due to that. It was not, and we had then no pulmonary signs to put us on the right track. We did not forget to look at the eyes. We looked at them but found no tubercles on the choroid. But on looking after death there was a large tubercle on the choroid of the right eye. It was so large that we could hardly have missed it when we examined the eye if it had been there, and therefore we learn that it must have developed very quickly, which accords with the fact that only one was found, for usually at death they are numerous in both eyes. And that leads me to the last point, namely, that you should always search the eyes, because tubercles in the choroid are by no means infrequent in cases of general miliary tuberculosis, especially when the tuberculosis affects the meninges, and as you actually see the tubercles with the ophthalmoscope, it is proof positive of what is the matter with the child. More than once I have been able to settle a doubtful diagnosis definitely by examining the eyes and finding tubercles. I looked at the eyes in this case only a day or two before the operation, but could not find anything abnormal. If a tubercle of the choroid had been there, trephining, with a view of finding an abscess and evacuating it, would not have been undertaken.

Papers by Guy's Men.

A Lecture on Chronic Obstruction of the Cæcum and Ascending Colon. Delivered before the Sydenham Medical Society, on November 20th, 1902. By W. Arbuthnot Lane, M.S. Lond., F.R.C.S.—*The Lancet*, 17th January.

Case for Diagnosis.

E. H., female, æt. 49, admitted for severe abdominal pain and collapse. The family history was unimportant. Patient had had a severe attack of influenza twelve years previously, and also suffered from two attacks of biliary colic. For the last two years there had been chronic constipation with attacks of abdominal pain which had always yielded to treatment—the last attack having been six month ago. There was no history of rheumatism or syphilis. A fortnight previous to admission was treated at home for bronchitis and an irregular heart.

At 11 p.m. on January 5th, patient was seized with acute abdominal pain chiefly in the left iliac region, and extending towards the umbilicus. This was accompanied by severe vomiting—which was not fæcal in character—followed by slight distension of the abdomen. The bowels had not been open for two days, and it was stated that up to admission at 7.30 a.m. on the 6th, there had been no passage of flatus.

On arriving in the ward, patient was in a very collapsed condition, the temperature being sub-normal; pulse very weak and irregular, rendering it almost impossible to count; respirations forty per minute.

The abdomen was slightly distended but moved well with respiration. There was tenderness in both iliac regions, and pain was felt all over the lower part of the abdomen. No tumour was felt. Pain prevented a rectal examination being made.

The liver was enlarged, extending down one and a half inches below the costal margin.

The heart was also enlarged, the impulse being in the fifth space in the left nipple line, and cardiac dulness extending one inch to the right of the sternum. No bruits were heard, but the heart sounds were very rapid (averaging 160–170 per minute), weak, irregular and intermittent. The pulse was absent at the left wrist, and just perceptible in the right radial artery. No pulses could be felt in the lower limbs. There were signs of chronic bronchitis, but patient was not cyanosed.

Shortly after admission, the abdominal pain departed, but there was severe pain accompanied by a feeling of numbness in the right lower extremity. This was partially relieved by hot applications. During the afternoon, patient rallied a little under the influence of the stimulants which had been given. Towards night she became worse, and complained of the pain in the right lower limb being most severe. There was no œdema of any part of the body noticed. At 8 p.m. the urine was drawn off by catheter, patient having passed neither urine nor fæces. The urine was only four ounces in quantity, containing 1¼ parts per 1000 of albumen specific gravity 1040, no blood, but some granular casts.

Patient sank and died at 4 a.m. on the 7th. Consciousness was maintained to within a few minutes of the end.

(For Solution see p. 60.)

Passim.

WE wonder if the present Temperance Legislation will answer in practice. The outcry for Temperance Reform, so urgently needed, has for so long been so wrong-headed, so ill-conceived, and so misdirected, that most impartial observers had almost abandoned hope of combating the great Liquor Trust, but the recent Act, which apparently was smuggled through in the confusion and heat of the education strife, without much attention, seems to us in every way admirable. We receive constantly extracts, letters and ex parte statements about "the cure of alcohol," and we often find that the proposed remedy is worse than the disease, but this sad fact only makes the new Act all the more striking and encouraging. It gives additional power to the authorities to deal with scandals connected with drinking, and that is wholly for the good. It institutes, as a moral and social stigma, a black list, whose penalties, however, we fancy will end there, except in the country, and it lays penalties heavy to be borne on the publican and all who encourage drunkenness. All this is sound, common sense reform, and we have nothing but hearty approval of the Act. It will do good, and it certainly can in no way act in the opposite direction, as we very much fear the reduction of public houses will do.

WE were driven to believe that the last effort at reform led to increased attendance of adults at public-houses, and that the bottle and jug entrance really met most of the criticism levelled at the infant messenger system, and we are quite clear that the tied-house system which flourishes so exceedingly, is the baneful result of well-meant temperance agitation.

IT has been remarked, however, that of late years there has been a decrease in the cases brought in drunk, or injured as the result of drink, and we believe the time is ripe for the reduction of alcoholic consumption. Public opinion, if we mistake not, is turning against the "whisky-and-soda man."

IN the City we have heard that there is quite a set being made against the most prevalent or pernicious habit of imbibing a glass of villianous raw spirit, mis-named Scotch, at every chance meeting, and it is even held that deals without alcohol are at any rate possible.

FOR ourselves, as medical men, we are no teetotallers, and do not profess to be, but we view the prevalent custom of always inviting a man to have a drink as a most intolerable nuisance, apart from its pernicious effects, and we believe quite half the casual "whisky-and-soda's" are drunk to avoid giving offence without any real appreciation. At the same time we hear of a movement (of course in the form of a League) to drink alcohol only with meals. We wish it success, and we hope some day that the provider of food and lodging, will, by a wise legislature, be invariably, and without restrictions, allowed the provision of alcohol with those meals, and that the "eating-house" may prosper at the expense of the "drinking-house." We hope to see a return to the "cakes and ale," and the extinction of the spirit craze.

AT the same time we do not wish to be held to endorse the extreme view and to uphold the furious denunciation of alcohol, root and branch, which some medical men put forward. We believe it with meals to be wholesome and often desirable, and in many cases of illness invaluable. We also know that most drunkards, among women, prefer to attribute their habit to medical advice, usually quite falsely, and we are inclined to believe that except among a somewhat undesirable class of people, the alleged great increase in secret female drinking is not borne out by the facts, but rather is the result of reiterated assertion.

WE feel deeply the want of a correspondence circle and of more contributors. One writer, referring to an editor, somewhat cynically remarked "the editor only cuts out what he wants." This is not, alas, our case. Did we sit with a blue pencil and shears there would be little to cut up, most contributions are "dunned" for, and the editor's pen is frequently employed tilling the ground (should he say the furrow?) rather than pruning the tree or plucking ripe fruit.

THE *Times* has from time immemorial been indebted to its correspondents—often the unpaid—for the most valuable expert criticisms, and we wish those of our readers to whose minds incidents are recalled of general interest would write them down briefly for our benefit. Also we stand to be corrected. In vain did we publish articles by great minds of medical and dental education and on most topics likely to interest our readers. The hydra-headed demos reads, but no answer is returned, no single reply or criticism was returned to any. Since October 1st no single contribution for "Passim" or the GAZETTE has reached us from the Dental School and except from the GAZETTE Committee, but two contributions from the rest of the Hospital.

THE *St. Mary's Gazette* contains a most interesting account by their late Senior Surgeon, Mr. Edmund Owen, of the Operations of the Pre-Listerian Darkness, a familiar but still deeply interesting theme, and it seems strange that the cleaner surgeons (in ordinary personal cleanliness we mean) never gained so distinct a measure of success as compared with the unwashed, dirty-coated man Mr. Owen describes, as to give some inkling of the truth. It is an address that is well worth reading in the library.

THE Swimming Bath has not proved so constant an attraction to the Nurses as to the Students and St. Thomas's Street. There are, just as in the Serpentine, several regular frequenters, and they have had the baths much their own way. It seems a pity the warmed baths do not attract more of the home-keeping (perforce!) Residents. It is very far from being the cold, comfortless procedure that the mind would picture.

INFLUENZA is rife with the thaw, and has attacked Dr. Perry, Mr. Jacobson and Mr. Dunn, and we regret to hear of the sudden illness of Mrs. Williams, wife of the genial Clerk to the Hospital, has necessitated a severe operation at short notice. Sister Clinical (Miss Strick) after a long illness and several operations will shortly be returning, we hope, in robust health, after a poisoned finger and cellulitis.

THE break-up of the frost has renewed the interest in our football players. McEvedy and O'Brien so caught the reporter's eye by their play for Kent, that it is yet possible more notice will be taken of them; and the team seems in fair fettle. But cup-ties are hard-fought games, and every joint in the harness is thoroughly tried, so it behoves all to see that they individually last right up to the finish, and then no slackness by reason of imperfect condition arises. Your half-trained man has ever no heart, and will not last up to the whistle. It is unfortunate, indeed, that we cannot rely on O. V. Payne, but we are glad to see Orpen back again in the three-quarter line, and trust his knee will hold.

Now that the Rugby Cup-ties are close upon us we think that it would be well to call men's attention to the necessity of training. The Cup must be won, and no doubt we ought to win it, but we hope that men will remember the shock we received on drawing with London last year, and see that they do not take things too easy nor undervalue their opponents' strength this year.

THE Annual Dinner of the Debating Society proved the greatest success in the Society's annals, owing we fancy to the overwhelming popularity of the genial chairman as a chairman and orator. It was in many respects a remarkable evening. The dining-room was crowded as we have never seen it before, and the speeches throughout maintained a high level and were followed in listening silence to the end, no mean test of their quality when some hour and a half was devoted to the oratory, a gift so rare and yet so strangely welcome. Nothing is more characteristic "mannish" as the desire that falls on any collection of individuals to hear each other speak, or as our dark coated confrères would say "to voice the aspirations of the community."

THERE was a general feeling of satisfaction with the intellectual and humorous oration that Dr. Savage had so kindly prepared for us. Reports of humorous speeches are always unsatisfying, and the delicate intonations, the

pauses, and the whole dramatic pose of the speaker, and his trenchant delivery, are almost impossible to reproduce at all, so that the reporter must not be blamed for the transcription. We regret the absolute impossibility of reproducing on cold, bare paper, in stiff, irresponsive type even the dry tones of the speech which the breath of the Master Magician had caused to live.

NOTHING strikes one more than the large number of good and capable orators to be found in the hospital, and the extremely low level of oratory found in other branches of society. The Church is notoriously feeble on the platform and after dinner, and even the lawyers are not so much better as their great practice and worldly wisdom would suggest, and also one often suffers much from hopelessly feeble public speakers.

THE Indian Medical Service examinations are just over, and we have lent to the East our recent Senior Charity, Mr. H. C. Keates, who, little over a year ago, narrowly missed the Gold Medal in Medicine at the London M.B., but oddly did not take a very high place in his recent examination. The unfortunate deduction must be that for Government Services the best plan is go straight in without, what we believe, the invaluable experience of such post-graduate appointments as a Resident.

WE are indebted to Surgeon-General W. B. Beatson for pointing out in a most interesting pamphlet—Indian Medical Service: Past and Present, a reprint from the *Imperial and Asiatic Quarterly Review*—the earliest appearance of a Guy's man in our Eastern Empire. The first two surgeons to Guy's Hospital were appointed April 9th, 1725, and J. Z. Holwell left Guy's qualified in 1732, after having been under the care and instruction of the Senior Surgeon; a privilege we all share nowadays, though at that time it was at the cost of indenture and personal favour that the benefits of hospital practice were alone obtainable.

HOLWELL maintained a heroic defence of Fort William for two days, and afterwards endured the stifling torture of the Black Hole; after a long and distinguished career, he succeeded Clive as Governor, but resigned shortly afterwards. The curious may find a full account in Busteed's "Echoes of Old Calcutta."

EMBASSIES in the reign of James I. were supplied with doctors and graduates of the English Universities, and thus early the distinction between a medical graduate and a barber-surgeon is shown by the fact, that in 1600 to each of the four out-going East Indiamen were appointed "Surgeons twoe and a Barber."

THE Physical Society, the most ancient and honoured of our societies, seems to have fallen on bad times. At the outset there were but twelve to hear the scholarly and erudite paper by Mr. Robertson, and though the number increased, there were but two to make any comment or voice any doubt. There are many who ought to support their hospital societies and speak at them, and we hope the attendance and keenness will alike improve. For the remaining meetings it is to be hoped more will be found to profit by what is obviously also their plain duty of attendance and support.

AN interesting auction took place during the meeting of the Staff to recommend the oncoming Residents in January. After dinner in the Charities' Room a selling sweepstake (?) was hastily organised; the entire proceeds were to be divided among those who bought the six winners. This, of course, necessitated caution, because until the pool mounted up, the individual value of the starter was very low, a fact which made Richards a cheap purchase. Each share realised eleven shillings. It is interesting to compare the results of the sweep with the results of the meeting, though, of course, the opinion of the room inclined rather to what the electors *would do* than to what they themselves thought of the candidate's merit. With this reservation we give the prices realised:—

A.H.S. (Front)	s.	d.	H.S.	s.	d.
*O. W. Richards ...	3	10	*C. H. Robertson ...	6	0
*A. R. Thompson...	2	6	*F. C. Wetherell ...	6	0
D. H. Trail	2	6	W. G. Parker	4	1
F. L. Thomas	1	7	G. T. Wrench.....	3	11
H. Moiser	1	2	S. Hodgson	3	0

A.H.P.	s.	d.
F. C. Wetherell ...	7	3
*S. Hodgson	6	6
W. G. Parker	6	2
*G. T. Wrench.....	3	6
H. A. Cutler	2	3

* Elected.

Thus, the meeting considered the H.S. appointments as safe for the Front Surgery candidates (an excellent rule) and O. W. Richards a certainty for the Front Surgery, but the A.H.P. gave rise to much strongly-backed doubt. One well-known Resident insisted that his friend should be run up to a decent price for his sake, a policy which eventually paid him. However, to the defeated we can only say, the majority of the *best* H.P.'s during the last four years have been defeated at their first application. It would be interesting to compare the above order of merit with that preserved in the Dean's office.

Appointments.

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants in Medical Wards.—Messrs. H. Ackroyd (Dr. Taylor); H. D. Smart (Dr. Hale White); F. H. Wallace (Dr. Pitt); H. F. B. Walker (Dr. Perry).

Ophthalmic Dressers.—Messrs. H. Tipping, R. G. Anderson (February 1st, Mr. Higgens); F. W. Fawssett, W. G. Parker (February 1st, Mr. Brailey); H. Watts, J. H. Donnell (March 16th, Mr. Higgens).

Surgeons' Dressers.—Messrs. P. P. Cole, M. G. Louisson, H. H. Jenkins, F. B. Lowe, W. S. Orton, A. V. Maybury (Mr. Lucas); A. E. F. Kynaston, M. J. Mottram, G. A. Ticehurst, D. H. Richards, R. M. Rendall, C. J. S. Dismorr (Mr. Golding-Bird); A. M. Webber, E. Lloyd, O. V. Payne, R. D. Bridger, E. C. Myott, F. W. Morton Palmer (Mr. Jacobson); H. H. Carter, G. H. Rees, G. C. F. Robinson, R. Franklin, B. Moiser, J. D. Thomas (Mr. Symonds).

Externs.—B. W. Lacey, G. F. Hardy, M. B. Taylor, H. M. M. Woodward, H. O. M. Beadnell, L. H. Frankenberg (February); K. Black, F. P. Hughes, R. A. Greeves, R. St. G. Seagrove, B. H. Stewart (March); P. A. Peall, F. Barnes, F. Rogerson, C. S. Morris, C. D. Pye-Smith, A. F. Hertz (April).

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Anti-Malarial Combine.

SIR,—You do me the honour of referring to the suggestion made in the last issue of *Climate* that a united movement should be set on foot for attempting to exterminate Malaria. In the course of your note you say "Without wishing to throw cold water, we can only feel that the onlooker's position must for the present be one of doubt as to even the theoretical possibility of this method of extermination, and further. as to the possibility of putting it into practice. It seems to us that as so, the drainage of all stagnant water is rather a large undertaking if that is what the theory amounts to, but we should welcome enlightenment on the subject."

Guy's Hospital is so distinguished for its representatives who have joined in the great campaign against Malaria, such as Dr. W. H. Crosse, Dr. P. Thurburn Manson, and also the late Dr. Washbourn and Dr. Pakes, who have especially interested themselves in this question from the pathological standpoint, as well as Dr. Howard, who is now in Central Africa, that I feel somewhat diffident in expressing my views on this subject.

Perhaps, however, you will permit me to point out that it is the extermination of Malaria and not the extermination of mosquitoes which is contemplated. It is proposed that this should be undertaken in the first place in great centres of population where the drainage of stagnant water should be undertaken, not only for the prevention of the breeding of mosquitoes, but on other sanitary grounds. It should be perfectly possible to deal with accumulations of stagnant water in the neighbourhood of most European settlements in the tropics, and if combined with this the other two methods of protection were employed, viz., the protection of the individual from mosquito bites by mosquito nets, etc., and the prophylactic use of quinine, there can be little doubt that a very large reduction would take place in the cases of malaria fever.

The great difficulty is that the medical profession generally has not realised the enormous practical possibilities which lie in this direction, and certainly the general public are not yet aware of the far-reaching importance of the recent scientific discoveries with reference to the propagation of Malaria. It is the special object of *Climate* to make available for the ordinary traveller the results of scientific discoveries which are likely to be of practical benefit to him, and I have to thank you for your kind references on more than one occasion to my journal.—I am, yours faithfully,

CHARLES F. HARFORD.

Livingstone College, Leyton, E. Editor of *Climate*.

January 19th, 1903.

Far Away.

December 18th, 1902.

DEAR SIR,—How well I can picture Guy's as I write this, for to-day I expect active preparations commence for Christmas decorations and festivities. It's difficult to realize that you are in mid-winter, whilst brilliant sunshine and summer reign supreme here. We form a little world of our own, so much so that we have a time all of our own; we put our clocks and watches on an hour because it is more convenient to the majority. The country round about is quite uninhabited except by natives. The scenery is fine; wherever the eye turns are huge rocky kopjes; these are well wooded, and the massiveness and wildness of them gives an appearance of grandeur I cannot describe. These kopjes are full of baboons, and early morning and evening we hear the "old men" holding forth to their families. Some also declare that they can hear the youngsters being severely reprimanded by their parents, who are stern believers in the "Spare the rod and spoil the child" theory. Personally my imagination carries me not thus far.

It was a five weeks' journey here via Beira, and the last nine miles I had to tramp as my train overturned owing to a washaway on the line due to the first rains of the season. This railway from Salisbury to the mine is only a two-foot gauge, and a train takes seven and a half hours to do the eighty-three miles. The engine burns wood as fuel. Some railways in England had better look to their laurels. That last nine miles' tramp was not a pleasant one. Spend five weeks on board, and then try nine miles over South African country in the dark.

Our town consists of a very fine hotel, which the new year will see in full swing, and which before very long will boast two billiard tables. Oh, Guy's men, who saunter into "The Ship" and order your half pint of Bass in a tankard, please breathe a sigh of relief as you place your 2d. down. There are places in the world where a small lager is 1s. 6d., a large 2s. 6d., and English beer 4s. a bottle. Whisky is 10s. a bottle.

Then also there is a store where one can purchase anything *at a price*. The manager's house and the hotel are our swell buildings, and very fine they are too. Some very nice cottages have been put up for married men, but many of the men here live in mud and lathe huts built by natives. These are placed in all sorts of nooks and out of the way corners of the kopjes. They are very picturesque in appearance and very cool to live in. My own dwelling place at present is made of tin and wood, and is very hot indeed, but next dry season new quarters will be built for me.

The natives employed in this mine have an undisguised terror of the doctor, and would sooner suffer anything than come into the native hospital. That to do so means death, seems to be the idea of one and all. Let me here explain that this idea was firmly implanted into their minds long before I arrived, or I hear a voice exclaim, "Bless the boy, what has he been doing to those unfortunate niggers."

They have three complaints, "A sore head," "pain in the ribs," "sore stomach." Diagnosis has to be made on that information, for as to history, or when they were taken bad, etc., etc., they seem to have not a notion. My Zulu orderly, who rejoices in the name of "Tom Morgan," has been very badly mauled by a lion, but he is a very smart boy and does all the dressing. This boy went to his kraal the other day on receipt of an urgent message; on his return he asked me the following distinctly puzzling question, "When a picannini cries all night till sunrise, what's the matter with it?" I explained that I thought white picanninies frequently suffered from this same complaint. He seemed very surprised, so I gather that a Zulu picannini is early taught in the way it should go.

The term here for boys shamming sick to get off work is not skrimshanking, the boy is said to "throw a sick." I suppose in the same manner as a patient at home "throws a fit." The boys complained to the native commissioner, who recently paid us a visit, that if they reported sick they were forced to go and see the doctor. It's really extraordinary the dislike they have to the doctor. When I was in the Transvaal the boys from the kraals for miles around would come for medicine, in fact the fowls and eggs they used to bring in return for medicine, proved a most welcome addition to the mess.

Saturday night here is the boys' great night; the Kaffir ladies from the neighbouring kraals bring in beer, and music and dancing is the order of the day, or night rather. They manufacture themselves rather a weird instrument known as a Kaffir piano, and they will sit and strum these for hours. If during the rests the boys happen to fall out, very severe casualties result, for if they do come to blows they make use of no half measures. It's all strongly reminiscent of the front surgery, Guy's Hospital, Saturday night sometimes. But they do not often fall out.

Our amusements here are tennis, rifle club, and library, and last but certainly most important, the gramaphone. I used to dislike the gramaphone in England, but whether it's been improved or whether it's being deprived of all other sources of music, the fact remains that we can all derive great amusement from it here, and we sit for hours at a time listening to it. Some strangers from off the veldt were passing through this property the other night and we had a gramaphone concert. "Mary was a housemaid," fairly brought down the house, and many heard "The honeysuckle," and "Dolly Gray" for the first time. What an inducement to come and settle in these out of the way places, the escaping of the song of the hour. The natives call the gramaphone, "The white man's indaba." There is not much shooting to be had close to the mine, but seven or eight miles out there is every variety of buck and antelope. Lions occasionally come quite close to the property, but this year they have not actually been

heard here though some donkeys were killed two miles away.

One feature, that must strike everyone who pays us a visit, is the splendid assortment of dogs we possess—dogs of every known shape, breed, and mixture. I think every white man has a dog, some two or three—awful mongrels the majority but still companions—and what a companion a dog is one never realizes till one leads a very lonely life

I believe some of the nurses who are engaged in England for this country find on arrival here that it is part of their duty to attend natives. If the nurse knows before coming that it will be part of her duty, well and good, if she realizes how desperately unpleasant it will be. But personally I don't think under any circumstances whatever ought a white woman to nurse a Kaffir, and I would advise all nurses very strongly to have this point very definitely decided before accepting any appointment out here.

Rhodesia. P. H. W.

The Debating Society's Dinner.

DR. SAVAGE took the chair at 7.30, supported by Dr. Shaw, Dr. Fawcett, Dr. Spriggs, Dr. Stevens, Mr. Bellingham Smith, Mr. Fagge, Mr. Ormond, the President of the Residents, and over 120 members.

After the loyal toasts, Dr. Shaw proposed "Prosperity to the Debating Society." In an amusing and witty speech in which "Lauryisms" were to the fore, he confessed that he himself never attended the meetings of the Society but he enjoyed reading the excellent accounts in the GAZETTE so much. The Hon. Secretary blushed. Mr. E. H. Griffin responded, and gave details of the Society's progress in his well-known style.

The PRESIDENT OF THE RESIDENTS said: Gentlemen, it is with much pleasure that I rise to propose the health of our President of the Debating Society—Dr. Savage. Dr. Savage has been well known to all of us almost since the day when we entered the hospital—and, I may add, is as popular as he is well known. One feature of his which we all admire is his fine sense of humour, a quality which—if possible—makes him the more invaluable as president of this society. Every man who has been to Bethlem Asylum must have seen Dr. Savage under varied conditions—at times modestly casting down his eyes under the tender endearments of some maniacal lady: at times braving the showered curses of some inmate with a grievance—but always preserving that grand bland smile which only adorns the countenance of men known as Fine Fellows. Gentlemen, I ask you to drink, "Dr. Savage."

Dr. SAVAGE, in rising to reply, was enthusiastically cheered. Now was to come the consummation of all things, and for this had the company *Waded* through many courses. The president began an exceedingly amusing speech, by relating an incident which would seem to be a most practical apologia for his well known methods of instruction. Five Americans, who had asked permission to be present at one of his lectures declared afterwards to the lecturer, "now they understood the use of the ridiculous in the teaching of medicine." It was many years ago (said Dr. Savage) since he, an ill-dressed pimply youth first entered Guy's Hospital. Many changes had come about, not only in the configuration of the bricks and mortar, but also among the men and women who inhabited the same. Gone was the watchman with his nightly cry, "one o'clock on a starlight night"—and gone was that watchman's scarcely less mediæval predecessor "John." The nurses, too, of to-day, were of a very different class from an old voluminous woman of his student days, who, standing with hands on hips, declared "We 'ave no nerves 'ere," pointing to the fire-engine, which then was in daily use as a treatment for hysterics, but which now was superseded by more humane if less heroic measures. Also the rivalry between our hospital and St. Thomas's was a thing of the past. In those days by an elaborate system of "scouts," bearers of accidents were lured to one or other of the sister hospitals by promises of "porter." Erysipelas, too, has fled before the steady advance of antiseptic surgery, and surgeons of to-day do not need to be maliciously threatened with a coroner's enquiry should they "attempt another ovariotomy." In those days, too, they always did die if they had holes made in their skulls. He would not say that they *did* work harder then than they do now, but he would say that they were *meant* to. He himself was H.S. and H.P., at least he shared the duties of the H.P. with old "Jimmy Stocker"—Dismal Jimmy, who like many an inveterate but untaught observer was possessed of a keen prognostic skill based on a remarkable sense of smell which you would hardly have expected had you noticed his breath. Passing from general to particular, Dr. Savage next recalled the names of many old Guy's men, some of whom were his teachers, and some his fellow students.

First there was *Gull*, "an eloquent, masterful man," amongst whose "gullible" followers (as they were called) it had been his privilege to be numbered. He recalled certain thermometers of Gallic origin, resembling rather the male catheter in their size and appearance, whose registers were conspicuous by their absence, "you watched the liquid rise in the tube." And these were to be used by Savage and two others in certain typhus cases in Clinical ward, with the result that the former gallantly persevered in the unequal combat, until, finding his confederates had been warded with typhus themselves, he thought discretion the better part of valour and abstained from further experiments with the catheter-like thermometers. Gull also had a theory that alcohol would cure typhus; but it was then a matter of common observation that convalescence from that disease was more rapid when the alcohol had been omitted. He recalled the names of several of his contemporaries, Hughlings Jackson, and Henry Sutton, his brother-in-

aw, opprobriously nick-named "Maggots," "because they always hung round the post-mortem room." Hughlings Jackson was among the first to use the opthalmoscope, he believed, amid the profound scepticism as to whether he *really* saw anything at the back of the eye which he described so minutely. But Gull, with prophetic insight, declared that it was quite within the bounds of possibility, and that he believed a time would come, when not only should we be able to see the back of the eye, but "right through people"—an obviously inspired reference to the X-rays.

Gull was generally considered infallible ; when going round Clinical, one day, he diagnosed a rash to be measles, in a case under the speaker's care, but on the following day it developed into the typical rash of small pox, and the men crowded into the ward "to see Gull had." Gull gazed at the patient in silence and passed on, to the disappointment of the onlookers. At the next bed, he turned round and said, "Gentlemen, measles, scarlet fever, and small-pox are easily distinguishable if you have a true history, *I had not.*" With regard to another patient, he enquired for any evidence of syphilis, and was told that the patient denied it. He examined the tongue and exclaimed, "Never believe a patient's tongue unless he has a node in it," which it had. Some years ago, Gull disbelieving in the Potassium Nitrate treatment of rheumatism, prescribed peppermint water in all cases with equally satisfactory results, while Dr. Reeve (?) treated them with lemon juice, giving rise to a parody—

"Rheumatic pains long time I bore,
Pot. Nitrate was in vain,
Till with the use of lemon juice
Reeve took away my pain."

A lady suffering from obscure intra-thoracic trouble, found that her pain was only alleviated by a daily bottle of champagne and brandy. Gull was called in, made a careful examination, and delivered himself thus:—"Madam ——, there comes a time in our lives when we may become young again. Young things take milk."

"She took milk, gentlemen."

Another of his teachers was John Hilton, who foreshadowed in his book many things now looked upon as new. His well-known work on "Rest and Pain" was even now a mine of sound and useful observation, while his dissections and preparations, from which Toone made his wax models, are world famous.

HILTON was alsc observant of trifles. He remarked the speaker wearing a rose (he had always been fond of flowers), and when the following morning he wore a forget-me-not, Hilton rapped out the query,

"Gal give it you again? I wish you would take as much care over your cases as you do over your flowers."

Next morning Savage wore a thistle.

He was a little brusque in his references, always unkindly referred to a catheter case of fractured spine as "Savage's false passage." When Savage took up Lunacy he called on Hilton. "You don't remember me?"

"Remember you, yes, and a d——d good dresser you were, I wish they were as good now."

"That's not what you used to say," returned Savage.

OLDHAM was another who will ever be remarkable for being the pink of good breeding and courtesy.

BADER was the oculist and prided himself on his English characteristics. He was a ready user of the ophthalmoscope at a time when its power was doubted. He, when called in to an obscure case in Clinical, successfully diagnosed a cerebellar tumour amid general incredulity, and proved his diagnosis at the autopsy. One day he was found enquiring for Langham, the boxer. He had been down to see a patient, who after the interview produced some big gloves and asked him if he cared to spar, he did so and was knocked out. Hence the enquiry. Two years later he went down again. "Take a turn with the gloves after the consultation," said the layman, with a twinkle in the eye. "With pleasure," and left his patient stretched on the floor. *Autres temps autres mœures.* He lived on the river Lee, not the notorious sink of the present day, and the speaker had often bathed with him on a Sunday, running along the bank until they were dry, an impossibility today. He once started to row in an out-rigged skiff and got in in state, top hat and black coat, promptly fell out on the far side, but came up in great dignity, hat still on.

MOXON was noted for his dissecting and his logic, he declared "knowledge to be the art of forgetting" like a caddis worm "you get a fact here and a fact there, till you think yourself quite original." He would have been the life and soul of the Debating Society. He held fast to a terse Socratic method of interlocution.

"In Memoriam, have you read it?"

"Yes."

"Do you like it?"

"Yes."

"Why?"

No reminiscences would be complete without Dear Old Wilks, whose pathological knowledge was so profound and whose interest so keen. He enjoyed a most extraordinary freedom in the wards, and often would come up to theatre and surgical wards in the pyæmia days to "see what you are getting ready for me." He said there were two classes of clerks, the industrious note-takers and the case-takers. The note-taker wrote down: Pneumonia. Dr. Wilks. Liq. Am. Acet. ʒi., and later on he would be called down and the proud father would say this case of pneumonia is being treated by your method by my son. Liq. A. A. ʒi. ! ! But still he was the real author of the phrase, "We don't treat the typhoid case but the typhoid person, therefore case-takers are no use as they treat cases and not patients."

WILKES had little belief in drugs but did believe in their proper use but said he often saw sedatives used as "graduated prizefighters" to lay one flat. He had a keen appreciation of the patient's condition, and though recognising that *worn out at 35* sufficiently explained itself, he said it was not a sufficient diagnosis from the patient's point of view. One day when called to see a man's wife who was purely hypochondriacal, to avoid

the unpleasant explanation he started on a tour round the room. "That's a nice picture, so's that," said he, till the anxious husband ejaculated, "I asked you to see my wife not my pictures." He said all diseases ought to be like jaundice, of different colours. Typhoid, blue; jaundice yellow; pneumonia, brown; and so on, and he declared that chlorotic girls always wore green ribbon. One day when called on to see the wife of a musical conductor, to the husband's great amusement he said the heart was so interesting, it had such a *musical* murmur. Six months later the G. P. called him down again to the same patient, remarking, "It's abdominal obstruction possibly due to a *band*." (Loud and prolonged cheers.) An inimitable, unproducible, but most humorous, intellectual treat was then brought to an untimely end by a few remarks on the Debating Society and apologies for what he must term at his stationary and introspective time of life an "abnormal outbreak of senile garrulity."

A. W. ORMOND proposed his health and a vote of thanks, and drew attention to Dr. Savage's dual capacity as President and Chairman, and declared the success of the dinner to be due to his personality. (Loud cheers.) He looked forward to Dr. Savage being the subject of innumerable reminiscences by those present. In time the philosophical give up looking forward, and are content to keep moving in the present. Dr. Savage was at that happy position, and he trusted he would long remain an interested spectator. (Cheers.) He would call on that genial personality the Editor to second the motion.

J. M. BRYDONE, supposed he was called upon to second the motion as an attempt to nobble the Press, but he was not the reporter. A few years ago he had attended a meeting of twelve persons, one was reading a speech, the rest newspapers. He rose to a point of order, and was promptly elected secretary. Nowadays the society rarely numbered less than sixty and often over a hundred. Could Dr. Savage carry his reminiscences down to the youth of those present? Several members visibly paled. Dr. Savage was the finest after-dinner speaker in London and therefore in the world.

Dr. SAVAGE, in reply, met with a great reception, but refused to be drawn into any more reminiscences, and thanked his hearers, and so with Auld Lang Syne ended the most successful and crowded dinner the Debating Society with all its successes in the last four years has ever held, for which no small credit is due to Messrs. E. H. Griffin and Ray Edridge, the joint and indefatigable secretaries.

IN the *Manchester Medical Students' Gazette*, p. 19, January, 1903, occurs a tale which we must claim, with pride, as a plagiarism from the defunct, but yet erst flourishing *Guyoscope*, relating to the discovery of an "ununited female under a cosmetics," most readers will remember the quotation, which will be found in the *Guyoscope*, Vol. i., No. 3, p. 33.

A Protest.

"Man, in his breathing, allies himself with the sheep and the rabbit; civilised woman falls into the class of the wolf and the tiger."—STEWART'S PHYSIOLOGY.

O, Physiology! 'tis true
That you're a most distressing science;
Henceforth I've sworn to offer you
Complete and absolute defiance.

'Tis not your often-changing way—
So feminine—that makes me sorrow,
I love to hear you prove to-day
What you will contradict to-morrow.

Nor is that my "muscle-nerve,"
Though demonstrators deign to make it,
Refuses to describe a curve,
'Til I—unfaltering—fake it!

From such mishaps one learns a lot
Of self-control and other habits,
But without protest I will NOT
Be told my breathing 's like a rabbit's.

Nor shall you, unreproved, suggest,
Without a trace of hesitation,
That all our nursing staff is blessed
With quite a tigrish respiration!

I do not mean to join the crew
That marches under Stephen's* banner,
But merely to suggest that you
Adopt a slightly sweeter manner.

For chivalry may be played out,
'Tis many years since Burke first said it—
Still don't you think that we may doubt
If it's entirely to our credit?

Guy's Hospital Nurses' Entertainment.

NEW YEAR'S DAY, 1903.

PART I.—Piano and 'Cello: Nurses Hill and Lulham. Song: Nurse Horsepool. Recitation: Nurse Atkey. Highland Fling: Nurse Danson. Song: Nurse Dennett. Farce:—"Wanted a Cheerful Companion": Nurses Horsepool and Wood.

PART II.—Piano Solo: Nurse Flower. Recitation: Nurse Wise. Song: Nurse Petitt. 'Cello Solo: Nurse Dawson. Song: Nurse Maddison. Scene from "Cranford"—Nurses Wise, Haslar, Webb, Worthington, Edmonds, Worthington, Mortiboys and Studdert. Plantation Songs: Nurses Petitt and others. "God Save King."

Sister Enid, with the assistance of the Nurses, is to be heartily congratulated on the success of the Christmas theatricals carried out by the Nurses. All worked hard, and the audience enjoyed the evening tremendously.

* Coleridge.

Reviews.

The price of books submitted for review should in every case be stated.

Abdominal Manipulation in Pregnancy. By Alexander Maclemman. (Rebman, Limited, London.) 6s. net.

The trend of recent opinion has undoubtedly been in the direction of upholding the doctrine this work embodies. It practically urges on all the importance of abdominal examination in pregnancy and its wide limits, to impress the point that vaginal examination is very often unnecessary.

There is much that is very true and well expressed, and the greater part of the book is well worthy of the study of the recently qualified. For the extern we like it not as it stands, and there are many things to which we must demur.

Under the diagnosis of pregnancy we are doubtful of the *ease* in which the round ligament in almost every case is very easily found, and of the recognition of the uterus after the third month by abdominal manipulation alone that is to say. Certainly this is not true in primiparæ till later.

Neither can we believe that the diagnosis of true pregnancy can be readily made by abdominal palpation; we can only say we have not seen it so easily made.

We likewise do not believe the onset of labour is *best* determined by abdominal palpation, nor that the progress is as easily determined.

But discounting these over-statements, the book is a distinct contribution to a much discussed subject and is well worth study, but from our own point of view we regard it as too much of an *ex parte* backing of the abdominal method to the detriment of proper vaginal examination.

Those whose repeated examinations entail a risk of sepsis have no right to attend confinements, and sepsis in midwifery we have no hesitation in saying ought not to arise. We may say that puerperal fever in normal labour attended by externs and nurses of a proper antiseptic training is almost unknown, and for their proper education we believe examination should be frequent.

The expert practitioner, we believe, uses abdominal palpation, auscultates the fœtal heart, and rightly makes at most but two or three vaginal examinations, and properly performed, we believe this implies no risk, but still there is a tendency *not* to practice abdominal palpation and auscultation enough, and this book will be a valuable reminder to many.

Practical Physiology. By Beddard, Edkins, Hill, Macleod and Pembrey. (Edward Arnold, London.) 15s. net.

This useful volume is a system of Experimental Physiology, by the physiological experts of Guy's, St. Bartholomew's, and the London, whose names speak for themselves, did not the book already do so.

The appendix contains a valuable analytical table for physiological compounds and substances, and throughout the book the illustrations are clear, the language simple and easy to follow, though the teaching is advanced and well up to date. We must own that the spectrophotometer is rather beyond the ordinary student's ken, and the estimation of the concentration of an unknown from the following equation would, in the absence of clear direction be somewhat crypt:—

$$C_2 = C_1 \frac{\text{log. tan. } O_1 - \text{log. tan. } O_2}{\text{log. tan. } O - \text{log. tan. } O_1}.$$

All the ordinary physiological experiments are given, and a great number of more recent processes described. It is a handbook to practical physiology that all advanced students should be acquainted with, and we consider it the best we have met with, and can thoroughly recommend it.

The Prevention of Disease (Translated from the German). By Wilmott Evans; Introduction by H. Timbrell Bulstrode. (Messrs. Archibald Constable & Co., Ltd.) 31s. 6d.

The large-printed, fat volume, which is a collection of essays by German writers, is one that we can thoroughly recommend. Throughout the style is good, the matter excellent, and the opinions dogmatic and strong without being in any way extravagant. The opinion of the editor that Preventive or State medicine is in its infancy and may have a robust manhood, is, we fear, however, ill-grounded.

Public Health Acts are feebly drawn and mostly ill-enacted, and for the most are not capable of extended use, as in many localities the very bodies that are responsible are unwilling to further the cause of hygiene; and with regard to the great question of venereal disease and its possible prevention, we fear it will be many a long day before the public will look facts fairly in the face and accept the inevitable and statesmanlike course of regulating what all deplore but are powerless to prevent.

We notice our old friend the gelatine treatment cropping up once more, a treatment we have always recoiled from, both practically as well as theoretically, and which is now but little used. The authors appear to be aware that poverty as well as sin is often the prime cause of disease, and that poverty is inevitable.

Of the various special articles, we think the article on gynæcology weak, perhaps because there is in our present state of knowledge but little preventive treatment beyond asepsis of the genital canal to trust to.

The prophylaxis in surgery does not deal, except indirectly, with the sterilization of instruments, skin, etc., but it is practical and well worth perusal.

The Prophylaxis of Preventive Disease is an article calmly and dispassionately written, and though we fear the remedies will never commend themselves to English-speaking races, yet the alternative is clearly pointed out and not obscurely hinted at.

A valuable addition to the usual text-books and a scientific work.

In the *Clinical Journal* of December 10th there is a most excellent and instructive lecture by Mr. H. T. Butlin on the "Special Causes of Death in Mouth Operations. It is quite one of the best we have read, and is a model of clinical instruction, and we recommend all to read it.

Aids to Forensic Medicine and Toxicology. Murrell. (Bailliere, Tindall & Cox.) 2s. 6d.

"This book will prove useful to students if used in the right way. It is not intended as a substitute for text books. It is simply intended to recall facts which have been acquired and properly digested." The above statement is absolutely true and we think the book a most useful publication.

Pass List.

Second Conjoint Examination, January, 1903.

R. D. Barron, L. Doudney, R. S. Harper, M. Leckie, E. C. Lowe, M. Maher, H. C. Malleson, B. B. Metcalfe, T. Norman, E. L. R. Norton, *N. H. Oliver, F. W. Parfitt, H. F. Wight.

*Physiology only, Four Years' Regulations.

First Conjoint Examination.

CHEMISTRY AND PHYSICS.—A. G. H. Buckby, W. W. Cook, M. M. Earle, J. S. Farnfield, *F. A. Husbands, *P. E. Luce, *J. W. Mawer, C. H. Mills, J. L. Rankine, *H. J. Russell, *H. J. Snowden

*Preliminary Science (L.D.S.).

ELEMENTARY BIOLOGY.—A. Angell, W. W. Cook, C. F. L. Leipoldt, L. A. B. Moore, A. D. Vernon Taylor, J. N. Watson.

PRACTICAL PHARMACY.—H. O. M. Beadnell, F. B. Lowe, E. P. Minett, J. O. Musson, F. H. Wallace.

Physical Society Meetings.

Feb. 11.—Paper, "Post Operative Treatment." By J. M. Brydone.

25.—Paper, "Pathological Conditions Associated with Phthisis." By H. F. B. Walker.

Mar. 11.—Treasurer's Prize Essay on "The Pathology of Chorea."

IN response to a notice in the last number the Editor has received several sums for the Theatricals, and the President of the Residents has received some donations, but until the two accounts are settled, a process we are powerless to accelerate, no list will be published, but we tender them our most grateful thanks.

WE should be glad to receive all notices of change of address amongst all old Guy's men during the past year, also of the setting of any in practice.

Sport.

Association Football.

GUY'S v. EWELL.

This match was played at Ewell on Saturday, January 10th and resulted in a draw of one goal all. Three of our men failed to put in an appearance and thus made our team rather weak! The game was of a very even character. Ewell were the first to score by means of their centre forward, who received a pass from one of the substitutes lent us. Soon after, from a strong attack by our three forwards, Norton scored with a splendid shot and the game ended as stated.

As no satisfactory explanation has been received from the men who did not turn up, it is presumed that they had something better to do. Team:—

GUY'S.—E. A. Collins (goal); A. G. Jones (back); A. W. Berry, A. F. Denning, and a Sub. (halves); D. C. Litchfield, E. L. R. Norton, C. H. Fothergill, and a Sub. (forwards).

Appointments.

CIVIL.

MARSHALL, R. PRYNNE, M.R.C.S. Eng., L.R.C.P. Lond., has been appointed Medical Officer to the Third District of the St. Olave's Union, and Certifying Surgeon to the Bermondsey Borough Council.

TIPPER, ERNEST H., M.R.C.S. Eng., L.R.C.P., L.S.A. Lond., has been appointed Refractionist to the Royal Eye Hospital, London.

Solution to Case for Diagnosis.

At the post-mortem, there was embolism of the abdominal aorta one inch above the bifurcation of the iliacs, with secondary thrombosis extending down each iliac artery to the profunda femoris in each limb. The right renal artery was completely occluded by thrombus. There was marked mitral stenosis, and the left auricular appendix was filled with ante-mortem thrombus which hung down into the cavity of the left auricle—a portion having become detached—causing embolism of the aorta. No embolus was found in the left upper limb.

The intestines were normal in appearance, there being no evidence of growth in the abdomen.

Birth.

HALL.—On January 7th, at Elstowe House, Itchen, Southampton, the wife of Edmund S. Hall, M.B. Lond., M.R.C.S., L.R.C.P. Lond., of a son.

Marriage.

ROUTH—PINNIGER.—On January 15th, at Saviour's Church, St. George's Square, S.W., Charles Frederick Routh, M.D. Lond., to Evelyn Mary, only daughter of the late Rev. H. H. Pinniger.

ED.—J. M. B.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, SECRETARY'S OFFICE, GUY'S HOSPITAL.

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING AND SIXPENCE.

Calendar of Coming Events.

Feb., 1903.

Sat. 14.—Messrs. Golding-Bird and Dunn's take-in; Drs., C. J. S. Dismorr and D. H. Richards; Cl., T. Morland Smith.
1 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., I., Lennox, home.
II., Lennox II., away.
III., Wasps, III., away.
IV., Dulwich III., away.
G.H.A.F.C., I., Reigate Priory, away.
II., Surbiton Hill, 2nd XI., home.

Wed. 18.—1.30 p.m., Clinical lecture by Mr. Symonds.
G.H.R.F.C., III., Blackheath School, away.
G.H.A.F.C., I., R.I.E.C., away.

Thur. 19.—Messrs. Jacobson and Fripp's take-in; Drs., R. D. Bridger and E. C. Myott; Cl., T. Morland Smith.

Fri. 20.—Meeting of the Dental Society at 4 p.m.

Sat. 21.—1 p.m., Clinical lecture by Dr. Taylor.
Dental Society's dinner at 6.30. Trocadero.
G.H.R.F.C., II., Rosslyn Park II., away.
G.H.A.F.C., II., Hampstead II., home.

Mon. 23.—1.15 p.m., Clinical lecture by Mr. Targett.

Wed. 25.—1.30 p.m., Clinical lecture by Mr. Symonds.
G.H.P.P.S., Pathological Meeting. Mr. S. Hodgson.

Thur. 26.—Messrs. Symonds and Steward's take-in; Drs., J. D. Thomas and R. Franklin; Cl., C. R. Howard.
Revision Classes for L.D.S. Eng. begin.

Fri. 27.—April Appointment List opened.

Sat. 28.—1 p.m., Clinical lecture by Dr. Taylor.
G.H.R.F.C., I., Marlboro' Nomads, away.
II., St. Thomas' II., home.
III., Old Charltonians "A" away.
G.H.A.F.C., I., Surbiton Hill, away.
II., Old Foresters II., home.

Guy's Hospital Gazette.

FEBRUARY 14, 1903.

Two Cases of Epithelioma.

CLINICAL LECTURE BY MR. LUCAS.

October 21st, 1902.

GENTLEMEN,—I have before me the reports of two cases of epithelioma, one of the tongue and the other of the floor of the mouth. One of these two cases is a patient who came in with epithelioma of the tongue and who is in the ward at the present time, having been admitted a short while ago. "He is 44 years of age and a carpenter by trade. He seems to have come of a very healthy family. His father and mother are quite healthy, the latter only having suffered from rheumatism. The patient has had no disease during his life. He first noticed, about four months before admission a small lump on his tongue. It gradually increased and of late has greatly inconvenienced him in talking and eating. The lump appears to have commenced on the left side of the tongue, on the side of his mouth where there is a notch in his teeth corresponding with the position occupied by his pipe in smoking. The patient had also noticed white patches over the surface of his tongue before this affection on the side of his tongue became evident, and he has of late also observed enlarged glands in his neck. These glands are on the left side underneath his jaw. He has suffered of late from great pain in his left ear running up on the left side of his head in the course of the auriculo-temporal nerve. The patient has some decayed teeth on that side. When he came in, the surface of his tongue was

noticed to be covered with white patches, and on the left side was an ulcer about the size of a sixpence with an indurated edge which was very sensitive and interfered with mastication. This infiltrated ulcer on the left side of his tongue was tender to the touch and distinctly hard as regards the surface immediately round it. There was no extension of the growth to the floor of his mouth."

I suggested to this man that he should have an operation performed, first, upon the glands of his neck, then on his tongue, and on the 22nd September the first operation was performed. An incision was made parallel with the lower jaw, and the submaxillary salivary gland was found infiltrated with growth and removed, and some lymphatic glands of small size in the immediate neighbourhood were also removed. Nothing more was done until October 7th, when the wound had healed, and then I removed the whole of his tongue. The history is very short —a few months only—but take note that some chronic irritation of his tongue had been going on for some long time, as indicated by the white patches of thickened epithelium on the surface of his tongue.

Here is another more serious case which was under my care a few months ago in which the epithelioma had attacked the floor of the mouth between the tongue and the lower jaw, behind, that is to say, the incisor teeth. This man is ten years older than the other—55 years of age —and a chimney-sweep by trade. He was admitted on the 8th of July last and discharged on the 23rd of August. His father appears to have died of hæmorrhage from the lungs at the age of 51. His mother lived to 73, when she died of bronchitis. There is no history of any cancer in the family.

In neither of these two cases is there any history of cancer, and if you search the histories of all the epitheliomata that come under your notice, you will find it extremely rare to get any history whatever of hereditary cancer affecting the tongue or mouth. Epithelioma of the tongue and mouth may be said to be almost invariably secondary to some chronic irritation of the surface dependent on causes which I will presently relate to you, but heredity as a cause appears to be almost entirely absent. This man says he has always been very healthy. As a child he had the ordinary children's complaints. From twenty to twenty-five years of age he had what I might almost say the usual adolescent complaint—a slight attack of gonorrhœa, but he denies ever having suffered from syphilis. When about twelve years of age he had an attack of rheumatic fever and made a good recovery. He has never had syphilis as far as we are able to judge. In the history of these two patients we find no evidence of syphilis, at any rate they do not admit it. In a considerable number of cases, epithelioma is known to follow upon those ulcerative conditions which, if neglected, exhaust and reduce the resistance of the parts to epithelioma, these ulcerative conditions being often the result of antecedent syphilis. This man seems to have had slight attacks of rheumatism, as well as an attack of rheumatic fever at twelve years of age. With regard to this, I may say that a French surgeon, named Verneuil, some years ago thought he could trace an association between a rheumatic diathesis and a tendency to cancer. I just mention that point, but I doubt very much if this man's relation to rheumatic fever had the slightest influence in the subsequent production of epithelioma in his tongue and mouth. It may be that people with a rheumatic diathesis are better lives and live longer generally than those who have a diathesis which offers little resistance to the bacillus of tubercle. Those people who live on, into, or past the middle period of life, have a greater liability to cancer than those who belong to a diathesis, which tends towards the ending of life at an earlier period.

I pass that on one side. This patient gave us a three months' history. "He thinks it was three months ago that he first noticed a small pimple at the junction of the tongue with the floor of the mouth—not on the surface of his tongue." He took no notice of it for the first month. After that it became more painful, and he stopped his smoking as he found that the irritation from the smoking caused him some inconvenience. He had had no treatment for the growth at all. The patient has been a fairly

average smoker. My ward clerk of that date, Mr. Cook, seems to consider a fairly average smoker one who smokes from half an ounce to an ounce a day. Well, I think seven ounces a week is a pretty good allowance, especially when it is rank shag which these men generally smoke. He says he is not a heavy drinker, but that he gets several glasses of beer daily from his customers, his occupation being that of a chimney-sweep. This man, when admitted, is said to be a medium-sized man, who looks fairly healthy. He has a swelling about the size of a shilling, situated just at the junction of the tongue with the floor of the mouth, on the left of the frœnum, so that the tongue is somewhat doubled back. What the ward clerk means to imply is that this growth has bound down and doubled the patient's tongue in, and he gives a little drawing to illustrate this. The swelling is hard, raised, and the centre is ulcerated, and the growth has a white margin. It is painful to the touch. The glands in the neck are not felt to be swollen. The patient's tongue is furred, but otherwise there is nothing abnormal about the surface. His teeth are sound and he has not been troubled with them. This man, you notice, is admitted for growth between his tongue and jaw. That is a very awkward situation for an epithelioma to attack, and it means that you have nearly always to perform a serious operation by division of the jaw before you can effect a complete removal of the growth. The operation which I proposed to this man and afterwards carried out, was that we should divide his jaw in two places, after cutting through his lip and chin, and remove the intervening portion of the jaw with the growth, because on further examination we discovered that this growth was not confined to the soft tissues underneath the tongue, but had become closely adherent to the jaw itself, and had made the periosteum of the jaw behind the symphysis part of itself. So that it would have been useless to have operated without at the same time removing a portion of the jaw. In the one case the tongue was the part affected, and the glands were obviously enlarged, and I operated on the glands before removing the tongue. In the second case the glands were not obviously enlarged, but there was a thickening which could be felt at the floor of the mouth, and it was necessary in order to eradicate the growth to remove a considerable portion of the jaw, and this operation was performed on the 24th July. A. C. E. and afterwards ether were given. The man seems to have struggled violently before he could be got under the anæsthetic. It is an almost certain sign when a man has to be given an enormous quantity of anæsthetic, that he has been a very free drinker, and has become accustomed to alcoholic stimulants. He took a large quantity of the anæsthetic before he could be got under the influence of it. A vertical incision was made through the left side of the lip and chin, because the growth was more to the left than to the right, and below the jaw. The total length of the incision was three inches. The tissues over the mandible were then dissected aside to the right, the right lateral incisor was extracted, and the mandible sawn through at this point. Next, the left flap was carried back, and the left first molar was extracted. The jaw was sawn through a second time where this tooth had been extracted. The tongue was pulled forward, and a large portion of the under surface of the tongue was cut away. The sublingual gland on the left side was also removed, as it was found to be infiltrated. The lingual artery was divided and ligatured. Some of the lymphatic glands, enlarged by growth, were also removed on either side of the median line below the chin. After the removal of the piece of jaw and the floor of the mouth, and part of the tongue as one mass, the two flaps of skin were sewn together by continuous horsehair sutures, and a sealed dressing was applied over. After that severe operation the man went on well. He was fed by a nasal tube, nothing being given by the mouth for some days, and he made a rapid recovery. But whilst he was still under observation, some enlargements of other glands were found, and on August 14th an anæsthetic was given, and an incision was made over the right submaxillary triangle, and the facial vein and artery were divided. A suppurating gland involving the submaxillary salivary gland was found on this side, and was excised. That will bear out a point that I wish

to impress upon you—that however well you may apply your disinfectant lotions or powders to the interior of the mouth, it is impossible to keep the mouth absolutely aseptic. What happens frequently in these cases, is that through the suppurative condition in the mouth, the lymphatic glands get infected and suppurate. This is much more likely to occur after the operation on the mouth than before.

In all the cases, therefore, where there is any glandular enlargement, and you are unable to complete the removal in one operation, you should first remove the glands of the neck, and secondly, proceed to remove the original growth in the mouth. If you proceed in the other direction, as was advocated a few years ago, that is to say, remove the original growth first and leave the glands for subsequent operation, what frequently happens is that the glands by that time have undergone suppuration, and it is almost impossible to get them away from the surrounding tissues to which they have become adherent.

I have related these cases as illustrating epithelioma of the tongue and of the floor of the mouth. I will now proceed to make a few remarks upon this very serious affection, which is one of the most painful and dangerous to which a human being can be subjected. First of all, I will repeat that heredity has little or no influence in the production of the disease. Next, I should point out that epithelioma of the tongue and mouth is almost four times more frequent in the male than in the female. This fact is probably associated with the tendency of males to smoke and irritate their mouths in this way. Also I think I may say that syphilis is a more frequent disease in the male sex than in the female. These two conditions, especially if they be associated, are apt to bring about a surface ulceration, spoken of as chronic glossitis, which leads to thickening of the epithelium of the tongue. A similar condition may affect the buccal mucous membrane or the floor of the mouth, leaving the thickened epithelium as a white patch, which has been variously described in its several stages as psoriasis, leucoplakia, leucoma, ichthyosis. This condition is really nothing more than the effects of a chronic surface irritation, often commencing in the secondary stage of syphilis, and kept up for years by smoking, or by long administration of mercury, and once fairly established is absolutely incurable. Powerful condiments or foul, decayed and angular teeth may also cause it. There is no drug and no local application which will get rid of these white patches when they have been established for any length of time. This condition means an exhausted surface, a surface which has lost its resistence, and it is on a surface like this that the organism—which has not yet been absolutely demonstrated, but which I have not the slightest doubt will be demonstrated before many years—the organism which produces epithelioma, finds a nidus in which it can develop.

Some people have thought this condition itself one of epithelioma. But I would warn you against proceeding to remove all the tongues, which come under your notice, with these white patches. A man may live to be very old without acquiring epithelioma if he takes care to avoid all irritation of these leucoplakic patches on his tongue. When this condition advances to a great extent the tongue appears to have a surface very much like a parrot's tongue, and years ago I suggested for this condition the term "parrot's tongue" or *psittacosis linguæ*, thinking that this name might avoid the use of terms like "psoriasis" and "ichthyosis" which are names of alien diseases bearing no relation to the tongue affection. This white patch condition is exceedingly prone in later years to terminate in epithelioma. A painful instance has come under my notice within the last two months. Some twelve years ago I took into my service, as groom, a twenty-one years' service Army pensioner, who had been an officer's servant during the whole of his military career, and who in many respects was a very admirable servant. He, like most men who have served for many years in the army, had suffered from syphilis. He was an inveterate smoker and he was not altogether an abstainer. He showed me his tongue first about ten years ago, and it was in the condition which I have spoken of, as like a parrot's tongue. I said to him then, "If you do not give up smoking

absolutely and avoid all irritation of your tongue, you will certainly die of cancer of the tongue at some future date." I frightened him temporarily, and I think for a few months he gave up smoking. But he took to it again, and I believe smoked more than ever. I was obliged to discharge him after five years' service because he became less and less able to resist the temptation to alcoholic excess. He then took a public house, in which he has been employed during the last seven years, and only last spring I heard that he had begun to suffer as I had predicted—from an epithelioma of his tongue. He died about two months ago, having refused to undergo an operation, in a terrible condition, from enlarged ulcerating glands in his neck and foul ulceration of the epithelioma of his tongue. I would, however, warn you, as I said just now, against regarding all these cases as hopeless. There is a gentleman whom I have had under my observation for the last eighteen years. He also had syphilis as a young man. He neglected the secondary stage and continued to smoke through that stage. He was a man who never had a cigar or cigarette out of his mouth when not sleeping, eating or talking. It is more than twelve years since he consulted me and he came to me with some fresh ulceration on his tongue and the surface in a state of psittacosis. I had his teeth filed off and I insisted on his giving up smoking. This man took my advice and has led a careful life since. He is well now, though quite advanced in years, and is quite free from any signs of epithelioma of his tongue. You must remove every source of irritation if you are to save these people. It is most important to file off any sharp, projecting, or irregular teeth and to scale them of tartar. My advice to you is, In treating any case of secondary syphilis, insist that the patient should give up smoking during the treatment. When there is any ulceration about the mouth, there is not the slightest doubt that smoking has a great deal of influence in keeping up the irritation. I have only once in private practice—I cannot speak so certainly as to hospital work—operated on a woman with epithelioma of the tongue. In that case she had married rather unfortunately and became infected with syphilis during the first pregnancy. From that time and for something like fifteen years she had constant sores about her tongue and mouth, which eventually ended in epithelioma of the tongue. That is the only case in a woman that I remember operating on for epithelioma of the tongue, and the disease was evidently secondary to chronic syphilitic ulceration, exhausting the resistance of the tissue to cancerous infection.

Mr. Hutchinson, about twenty years ago, drew attention to other conditions which he spoke of belonging to a pre-cancerous stage of cancer. He included among these warts which occur about the scrotum in chimney-sweeps, and ended in epithelioma of the scrotum, "chimney-sweep's cancer" as it used to be called. Other sources of irritation which may lead to epithelioma include smoking with clay pipes, causing scaling and superficial ulceration of the lower lip; balanitis which is associated with contracted prepuce, and may cause epithelioma of the penis; also eczema of the nipple to which Mr. Paget drew attention, and which may lead to cancer of the mammary glands. Another source of irritation to which I have already alluded is the rubbing of the teeth against the side of the tongue. Very often men's teeth get quite sharp in situations, which are easily rubbed down by dentists. If I see any sign of this rubbing about the tongue or cheek I always send the patient to a dentist to have the teeth filed or the offending tooth extracted. Some twenty years ago I saw a gentleman with ulceration of his cheek who had been condemned for epithelioma, and who had been advised to have a portion of his cheek cut away. It was a short history, only some eight weeks from the time it was first noticed. I discovered a tooth with a sharp edge and an irregular amalgam stopping, which, when he shut his mouth, just fitted into this sore in his cheek. I said, "Before you do anything rash I think it will be well to have that tooth extracted." It was accordingly extracted and the ulcer entirely healed, and the gentleman is still living. He is a director of an assurance company in the city, and is still in perfect health. If the history of ulceration be short, there is a

chance of healing the sore by removing a local source or irritation before more serious consequences have ensued.

Scars of burns sometimes end in epithelioma, and not infrequently chronic ulcers of the leg do so also.

I will just say a few words about the diagnosis of epithelioma of the tongue. It is a disease which runs often a very rapid course. The history of one of these cases, I think, was only three months and the other four. *Primary chancre* of the tongue is one of the things which might be mistaken for epithelioma. I have seen only one case of this, and the patient was a clerk in the city between 50 and 60 years of age. He had a toothplate in the roof of his mouth, from which one tooth had become detached, and immediately opposite where this piece of sharp plate touched his tongue he had an ulcer. When I first saw the ulcer he had no secondary symptoms. I told him to have the toothplate altered and to use some simple lotion. He showed the tongue to me a week or two later, and I was surprised to see that although the plate had been taken out the sore had become more thickened round the edge, and a little glandular enlargement could then be felt underneath his chin. I am bound to say I began to think very seriously of this case, and the possibility of its being a chancre did not at first occur to me as he was a man holding a high responsible position. A week or two later when I saw him, I thought I detected a little spot or two on his forehead, and then, on examining further, I found that he had a secondary rash appearing. I treated him with mercury, and cured him of his chancre and of his rash. How this came about I will not make any suggestion, but there being an ulcered surface produced by a sharp plate, you can easily understand that any syphilitic virus coming into contact with it might be inoculated and produce a chancre. That is the only case of chancre of the tongue I have seen. In this country I believe it is a very rare condition. The occurrence of a rash would open your eyes to the possibility of chancre. The history would not be very long, the rash generally appearing about six or eight weeks after infection.

Tertiary gumma is more difficult to diagnose from epithelioma. This is the result of syphilitic deposit, producing a lump in the tongue which breaks down and leaves an unhealthy-looking, ragged, sloughing surface. The fact that it begins as a roundish lump, generally in the substance of the tongue near the middle rather than at the edge, and that it breaks down and leaves a sloughing-looking surface with a ragged edge—will enable you generally to distinguish it from epithelioma, which almost invariably begins as an ulcer on the side or edge of the tongue. Anti-syphilitic treatment will cause the sloughing surface to resolve itself, and a healing process will rapidly take place. There may, however, be enlarged glands during this stage, as there are during the first or chancre stage, but these glands are not so hard as those infiltrated with epithelioma. *Tubercular ulceration* of the tongue is usually associated with phthisis. I saw a gentleman suffering from tubercular ulcers who died about a year ago from phthisis. He consulted me on several occasions for ulceration about his tongue and mouth, which was clearly of a tubercular nature before phthisis became developed. There was one which troubled him very much at the angle between his tongue and jaw, an ulcer with very slightly thickened edge, and a ground glass kind of surface, and I found it exceedingly difficult to do anything to relieve it. Some boracic powder seemed to do it more good than anything else. The fact that I had removed tubercular glands from his neck ten years before, made me suspicious of tubercle.

Papilloma of the tongue may also be thought to be epithelioma. In simple papilloma of the tongue there are no enlarged glands, and the raised vascular tufts are soft.

I will go over the symptoms once more. An epithelioma of the tongue most frequently begins on one side of the tongue, or it may begin under the tongue in the floor of the mouth and spread to the tongue. It begins generally as a little sore on a little fissure, or as a little thickened lump, with perhaps a faint sign of a crack in it. Then the thickening spreads and the ulceration increases. As the infiltration increases there is a lack of mobility in the tongue so that the man begins to talk a little thick as he speaks, because

he cannot move his tongue easily. He finds that in swallowing there is some difficulty, because his tongue does not move readily back. He finds, too, that in mastication he has a difficulty, because the lack of mobility in the tongue prevents its proper use in moving the food from one side of the mouth to the other, and from between the teeth. In the late stages the movement of the tongue during mastication becomes excessively painful, and the pain produced by even slight movement of the tongue induces an excessive secretion of saliva; whilst in the most advanced stages the saliva often dribbles continuously from the patient's mouth. Another thing that a person with this disease suffers from is intense pain in the ear and up the side of the head on the same side as that on which the epithelioma is developing. This man suffered from great pain in the ear (I am speaking of the case of epithelioma of the tongue, and not of the floor of the mouth) and after I removed the glands from his neck we found he was in no way relieved of this intense pain in his ear and the side of his head. The causes of the pain was the open sore on his tongue, exposing some of the filaments of the lingual nerve of the third division of the fifth, the pain being transferred to the auriculo-temporal. Intense ear-ache is often caused by decayed teeth in the lower jaw. Decayed teeth in the upper jaw seldom cause pain in the ear, the teeth here being supplied from the second division, whereas those of the lower jaw are supplied from the third division of the fifth. The enlarged glands are usually hard, harder than those from simple or syphilitic inflammations, and they are apt to increase very rapidly. There are no less than four sets of lymphatics and glands associated with the tongue. There is one set in the median line, the *submental*, which was affected in the case in which I removed part of the jaw. There is another *submaxillary* set which drain through the submaxillary triangle and the submaxillary salivary gland. The third is the *carotid* set, which lies over the carotid artery, and the *parotid* form the fourth group. These four sets of glands are liable to be affected by disease of the tongue. The submaxillary and the carotid sets are by far the most frequently affected. The submental set are usually not affected unless the floor of the mouth or the median line of the tongue in front is affected. The parotid set drain especially the back of the tongue, which is the part least liable to disease.

The later stages of this disease, when it is left to its natural course, are very terrible to witness. The patient is racked with pain night and day. Deglutition or the slightest movement of the tongue sends lanceolating pains through the various branches of the fifth nerve, and later the branches of the cervical plexus sympathise in the agony. A foul-scented ulcer emits a sickening fœtor which makes his breath unapproachable, and perhaps infects his lungs and excites there a septic pneumonia. Saliva mixed with discharge flows from his mouth. Frequent hæmorrhages are apt to occur from the ulcerated surface, gradually reducing his remaining strength. The glands in his neck grow rapidly, and by their pressure encumber still more the painful efforts of deglutition, and render respiration difficult. After a time they burst, fungate, and discharge a loathsome ichor, whilst in the stretched skin ulceration rapidly extends. Worn out by pain and loss of sleep, half-starved through inability to swallow, his nourishment sapped by constant discharge and intermittent hæmorrhages, he grows feebler whilst emaciation rapidly proceeds; his complexion assumes a yellow tint, as in chlorosis, and his hollow temples, bleared sunken eyes and wasted frame indicate the approaching end. This may be from simple exhaustion, from septicæmia, pneumonia, or hæmorrhage from one of the branches of the carotid artery. Happily, operation may do much to prolong life and relieve the distress of this terrible disease. Though too often the disease recurs and eventually proves fatal, in some cases a complete cure is obtained by free and early excision.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only

Arterio-Sclerosis.

A paper read before the Physical Society on January 28th, 1903, by Mr. C. H. ROBERTSON.

GENTLEMEN,—In the paper which I am going to read before you to-night, I propose to confine my remarks to arterio-sclerosis in its diffuse form; that disease which was called by Gull and Sutton "arterio-capillary-fibrosis." That is to say, I wish to exclude those diseases of arteries which are due to definite causes such as syphilitic and tubercular endarteritis, and also, as far as possible, the nodular form of atheroma, although recognising that there is probably some intimate connection between all of them.

The title I am told sounds somewhat "dry," but surely here is a certain amount of interest attached to this subject, when we remember that among those of us who will live long enough, few will escape the disease.

We can all think of cases in older men than ourselves, whose memory is not quite so good as it was, or whose capacity for doing any of the more extraordinary duties of this life, has almost left them; these are symptoms of this insidious, but I think, fairly curable disease.

To take the symptoms in more detail, on thinking them over, you will find that the final and more serious are the symptoms of diseases called by different names, such as chronic Bright's disease, cerebral softening, senile dementia, gangrene, aneurysm, or angina pectoris. Of more interest to us with regard to the treatment are the earlier symptoms; these may be divided into the physical and mental. Physical—the patient begins to find that his accustomed exercise is rather more trouble than it used to be, he does not seem to be able to get his "second wind," so that any exertion is accompanied by difficulty in getting breath, and a sense of constriction round the chest. Instead of merely a sense of constriction, there may be true anginoid pains. In nearly every patient the ungs are emphysematous, therefore they suffer a good eal from chronic bronchitis. Sometimes there are chronic joint troubles, so that chronic osteo-arthritis may be associated with chronic arterio-sclerosis, a point which Lauder Brunton thinks of some importance, as he points out the similarity in the treatment of the two diseases.

The mental condition is often interesting, the patient showing the same dislike to mental as to physical exertion. He feels it a trouble to be introduced to new friends, the effort of conversation being rather much for his non-elastic cerebral vessels. Slight fainting fits are common, also dizziness and forgetfulness.

Lauder Brunton quotes a case of a man who had a slight fainting fit and was rather stupid for two days afterwards. He made an apparently complete recovery, ut it was found that though he could *write* numbers on cheques he was quite unable to put down figures. Such a case as this inclines one to the theory that these, what almost might be termed functional symptoms, are due to some of the debris from an atheromatous abscess lodging in minute branches of the cerebral arteries. Besides these *symptoms* there are the *signs* of thickened arteries, and, as Thoma points out, thickened veins, the signs of hypertrophied heart, albumen in the urine, etc. One early sign on which it seems to me great stress ought to be laid is that often the first artery to show degenerative changes is the retinal; later on this developes into that distinct condition known as "albuminuric retinitis." Bader was the first to point out that slight hyaline changes can be observed in the retinal artery at the commencement of this disease.

CASE I.—Clinical No. 3. Admitted for shortness of breath. The following are the short notes made:—

More refined than the usual hospital patient. Florid-looking man with thick arteries; anginoid attacks; rather deaf; slow cerebration, and some days he appeared to be in a somewhat elevated mental condition resembling G.P.I.; other days he seemed quite normal. For the first few days he was orthopnœic, but soon recovered. There was an enlarged heart with a variable apical bruit; emphysema and bronchitis; a little albuminuria, which cleared up. He was treated with lobelia and Pot. Iod. and when anginoid pains were present he was given nitrites. He rapidly improved under this treatment.

You notice that the symptoms will vary according as to which artery or group of arteries is most affected.

I will now draw your attention to the *pathology* of this disease:—First, let me draw your attention to the fact that, although this disease generally belongs to those of more mature years than ourselves, it is *not* exactly dependent on mere years, for besides one or two cases described in young adults, such as the negro mentioned in Osler's text-book, we all know of men over sixty who possess as much mental acumen and physical activity as some of those of only fifty years, whose arteries must, therefore, be in better condition than those of the young negro. Heredity, alcohol, lead and gout play a part in the etiology. The most important etiological factor, however, seems to be hard work, given either to the stomach in the form of good living, or to the muscles as manual labour.

Among those whose occupations involve an increased number of heart beats, and thus a more or less permanently heightened blood-pressure, are found the majority of cases. The blood-pressures have been taken of Russian peasants in winter and summer (these men only do hard work in the summer months), and in them it is found that the general pressure is greatest during the working season, and falls again in the slack season. These men do not suffer from arterio-sclerosis. On the other hand, those who have hard manual labour all the year round, *e.g.*, soldiers and sailors, do suffer from arterio-sclerosis. These effects seem to be quite apart from those causes such as alcohol, which must be put down to a toxin circulating in the blood.

A purely physiological occlusion is found to take place in certain arteries, *e.g.*, in the Ductus Botalli, in the

vessels of stumps after amputation. The thickening of the intima in both these cases is exactly similar in its histological details to that found in the preliminary stages of arterio-sclerosis.

A still further example of what might be termed a physiological arterio-sclerosis is found in the common carotid. A subendothelial thickening has been normally found to occur, the explanation of this offered by Sach is that the carotid reaches its full development by about the tenth year, *i.e.*, before the rest of the arterial system, so that for some years there is an increasing pressure in the carotid, naturally succeeded by dilitation, and as soon as the elasticity begins to fail, the above-mentioned subendothelial compensatory growth takes place. Before going any further allow me to briefly recall some of the histological appearances observed in the arteries.

The muscular tissue found in the middle coat is found to have undergone a hyaline change, with the result that it becomes shrunken, in some places more than others. In the intima will be seen a new growth of round cells, and this growth is most prolific opposite the sunken spots in the media. In time the new cells in the intima become resolved into fibrous tissue, and the vasa vasorum are thereby compressed, till finally the blood supply to the patch is cut off, leading to softening and breaking down, until conditions are found which are known as atheromatous abscess and ulcer.

This intimal growth is by some supposed to be of inflammatory origin and derived from the vasa vasorum; by others it is looked on as a proliferation of the endothelial cells, as a provision of nature to maintain uniformity in the size of lumen of the tubes, for if it were not for this new tissue there would be depressions opposite the places where the media was most diseased. I may mention that this weakening of the media is the cause of the development of an aneurysm, and as soon as the weakness is compensated by intimal overgrowth, the tendency to the formation of aneurysm goes, so that there is a period in the disease of about a year when aneurysm may develop, should this period be tided over the patient may consider himself safe.

The most interesting point in a discussion of this disease is what is the actual cause of the atheroma? Thoma, who has made an exhaustive research on this subject, is of opinion that the whole process is due to change of rapidity of flow of the blood current. He points out some of the physiological changes narrated above, and comes to the conclusion that as the blood current is slowed, for example in the ductus arteriosus after birth, so the vasa vasorum become more dilated with blood. This extra nutriment flowing in the small vessels is the direct cause of the connective tissue growth. When the growth has so far grown as to diminish the lumen, and thus cause a return of the normal blood flow, the vasa vasorum are no longer dilated and so the growth stops. Thoma explains this dilation of the vasa vasorum, on the assumption that it is actuated by the Paccinian corpuscles which he has found in the coats of arteries, to these bodies also he attributes the pain of aneurysm in its early stages.

This almost purely physiological theory does not, I think, account for those cases where arterio-sclerosis appears to be due to lead or some other form of poison.

So far, I have not touched on the vexed question of whether the kidney or the artery is the primary lesion of arterio-sclerosis. On Thoma's hypothesis the kidney is more likely to be first affected, thus causing an alteration in the blood flow, and so leading to the change mentioned above.

Johnson also argues that the kidney is first affected, and the diseased condition of this organ then leads to a deficient excretion of the poisons circulating in the blood. These poisons cause a contraction of the muscular coat, and so increased blood-pressure and hypertrophy of the heart. This continual high pressure, he says, leads to a chronic hypertrophy of the vessel wall.

One of the most important early papers on this subject is to be found in the Guy's Hospital Reports for 1872, by Gull and Sutton. They differ wholly from the views enunciated by Johnson. They argue that the kidney need not necessarily be first affected, but that the first change to be noticed is a hyaline degeneration in the adventitia of the arterioles. If this hyaloid change of the arterioles begins early in the kidneys, then these organs will be found in a state of advanced "interstitial nephritis," compared with the rest of the arterial system. In support of this fact, in the paper above-mentioned, three cases are described where extensive arterio-sclerosis was found, and no kidney disease. The heart was hypertrophied in these cases. In nine other cases interstitial nephritis was found, but *no* cardiac hypertrophy. Gull and Sutton did not believe, therefore, that disease of the kidney alone could so raise the blood-pressure, as to cause hypertrophy of the heart; they point out that in chronic primary kidney troubles such as tuberculous pyelitis and lardaceous disease, an enlarged heart is rarely found, and in those cases in which it is found, hyaline changes will be seen in the vessels.

A great objection raised to Gull and Sutton's work is that the change they describe as the "hyaline fibroid" in the vessel wall, is really due to the action of the glycerin used in the preparation of the microropic slide. Whether this is true or not I am not competent to judge, but I think the examples they draw attention to of diseased kidneys and normal hearts do not prove that the kidney has no influence on the blood pressure, for you will remember, that if a duct of a gland such as the ureter, or a salivary duct is completely blocked, no hypertrophy of the organ behind takes place; but if there is only a partial blockage of the duct, hydronephrosis or hypertrophy of the respective organs occur.

Are not these conditions similar when we look at a kidney (*a*) subject to tubercular disease, and (*b*) subject to interstitial nephritis? In the first there is a total destruction of tissue, and in the second there is only a narrowing down of the arterial lumen, the latter case corresponding to partial blocking of a gland duct.

In syphilitic endarteritis, Thoma has shown that it is the vasa vasorum that are first affected. If this is so, is it not likely in arterio-sclerosis also, the vasa vasorum affect the vessel wall and produce the disease. The fact that atheroma occurs in patches is often regarded as showing the origin from diseased vasa vasorum. If we accept this, the many factors involved in the etiology, such as alcohol, gout, and even continuous manual labour, can be classed under one category, for each of these involve an impure condition of the circulating blood. Continuous hard work, because their being increased metabolism, there must always be some effete product in the blood.

These various toxins may not affect the more robust epithelium of the larger arteries, but when brought in contact with the delicate epithelium of the vasa vasorum, an arteritis is more easily set up.

The various forms of so-called physiological occlusion can also be explained on this basis, for the circulation in say the ductus arteriosus being suddenly diminished, the vasa vasorum lose their accustomed quantity of nourishment, and thus perform badly their function of nourishing the arterial wall. The Paccinian corpuscles described by Thoma will no doubt control the vasa vasorum during slight differences in the circulation, but any such sudden alteration as that which occurs in the ductus arte iosis at birth they will be unab e to cope with. My views on the cause of arterio-sclerosis are, therefore, that it is entirely a question of the quantity or quality of the blood nourishing the vessel wall.

With regard to the *treatment* of the disease, I have no intention of describing the treatment of the advanced stages, as when it can be truly called chronic Bright's disease, but that of the initial condition.

Regarding this malady as depending on imperfect nutrition of the vessels, the effect of treatment will be directed towards a purer supply of nutriment.

In between the coats of an artery are found lymph spaces and lymphatics, and outside the artery you will remember there is a tough fibrous sheath, so that during every diastole there wi l be dilatation of the lymphatics. As a result of this dilatation lymph will be sucked in from the surrounding tissue; on contraction or systole, these lymphatics are emptied, the direction of the lymph flow being controlled by numerous valves. It will be our aim, therefore, to insure an effective contraction of the arterial muscle, and this is best obtained by exercise. If the patient cannot be induced to take ordinary exercise, the Schott method is of great use, especially the carbon dioxide baths used in this form of treatment which dilate the vessels of the skin.

Lauder Brunton greatly recommends the drinking of much water, which will act as a diuretic and will temporarily dilute any toxic property the blood may have.

It will seem like taking coals to Newcastle to recommend exercise as treatment for a disease which can doubtless be caused by excess of exercise, but I do not refer to exercise which is so excessive and continual as to almost permanently raise the blood-pressure. Those people whose atheroma arises from good living, are always badly in want of exercise (massage would have the same effect by alternately compressing and relaxing the arteries).

If the tension is found to be very high, the artery obviously cannot expand and contract its lymphatics so well, as when the tension is normal, therefore, in cases of high tension nitrites will be of great value, by relaxing the tightly-constricted arteries, and thus giving more freedom for their expansive and contractive movements.

I must not conclude without mentioning that omnipotent drug pot. iod., which seems to have some specific action on this disease as it has on osteo-arthritis.

Mr. BOLUS wished to know why the veins are not more frequently affected with arterio-sclerosis, since the rate of circulation in them is much slower than in the arteries. He further wished to know whether arterio-sclerosis is compatible with health.

Dr. BEDDARD quoted the case of a paperhanger who complained of headache and giddiness. He had general arterio-sclerosis, a normal sized heart, and normal urine. Lead, gout, syphilis, and heavy work could be excluded. He appeared to be a case of general arterio-sclerosis without high blood-pressure, and in whom the blood-pressure probably never had been high.

Mr. LOUISSON asked whether there was any reason to believe that patches of atheroma mechanically narrowed the lumen of the arteries.

Mr. ROBERTSON, in reply to Mr. Bolus, mentioned that arterio-sclerosis did frequently affect veins and was probably incompatible with perfect bodily and mental health. In reply to Mr. Louisson, he pointed out that impressions of the lumen of an atheromatous artery showed no trace of a projection of the patch into the lumen of the vessel.

Appointments.

CIVIL.

EVANS, JOHN, M.B. Lond., M.R.C.S., L.R.C.P., has been appointed House-Surgeon to the Stanley Hospital, Liverpool.

LAMBERT, F. E., L.D.S. Eng., has been appointed Assistant Dental Surgeon to the Brighton Dental Hospital.

WOOD, W. R., M.R.C.S., L.R.C.P. Lond., L.D.S. Eng., has been appointed Dental Surgeon to the Brighton and Sussex Throat and Ear Hospital.

The Secretary of State for War has approved of the appointment of the following physicians and surgeons as clinical teachers to the Medical Staff College:—

Medicine: Dr. W. Hale White.
Dental Surgery: Mr. J. H. Badcock.
Laryngology: Mr. F. J. Steward.
Midwifery and Gynæcology: Dr. W. R. Dakin.
Psychological Medicine: Dr. Maurice Craig.

Passim.

The changes occasioned by Dr. Galabin's retirement have now taken place. Dr. Horrocks has taken the Maze Pond division with fourteen beds, and Mr. Targett has succeeded to the remaining ten. Mr. Bellingham Smith has succeeded to the Assistant Obstetric Surgeoncy (or Physiciancy?) and Mr. H. T. Hicks has been appointed Registrar. To all we offer our hearty congratulations. We hope to publish a portrait of Dr. Galabin shortly, uniform in design with that of Sir Henry Howse, which appeared last autumn.

We were wondering if we ought to have been affronted at the post-card addressed to us recently,

The Editor,
The "Guyoscope,"
Guy's Hospital,
London.

but on turning over, our hospital pride was so flattered that we were unable to feel resentment. For was it not a *written* request from no less a body than the Bodleian Library, Oxford, for the missing copies of the *Guyoscope*, Nos. 1–4, 6–8, 12, and all after 18? "We are very desirous of making our set of the above complete, if possible. We should be glad, therefore, if you could send us the following numbers in which our set is deficient." Posthumous fame, archival glory, and yet 'twill cheer the scattered and vivacious authors of this much discussed publication, whose demise eclipsed, if not the gaiety of nations, was at any rate, a great and intense hospital interest. Will any help?

The relations between the Hospital and the Press seem somewhat unsatisfactory. We are, perhaps, inclined to think that we are somewhat harshly dealt with as a rule, and somewhat coldly praised for our successes. Take hospital football for example. For many years past, we are quite sure for fifteen years at least, the premier and second hospitals have been capable of giving some of the best clubs in London, always at least a hard and good game, and very often a beating. Take our records with the University of Cambridge and Blackheath; remember they are always played away from home and at a time when we are usually at our weakest, and yet last year we beat Blackheath and this year both Oxford and Cambridge, and yet the press refer to it very tamely, and in the account of our game with Bart.'s says, "If Morgan had been unable to play Guy's would probably not have won." Without disparaging that player at all, we think that we should certainly have won without him on the day's play.

Other points are that Guy's among other hospitals is constantly sneered at and criticised in the Press for not doing what hospitals were not, are not, and often cannot well do. Take the prevention and detection of crime. When a policeman brings in an injured man, surely all but the medical treatment rests with the policeman and his superiors; it is no part of our duty to cross-examine and piece theory into fact. As a matter of fact all police cases are instantly seen by the House-surgeon, and the numbers of the "Bobbies" are recorded alongside the entry together with more detailed notes, and *no* police authority has ever been hampered in his enquiries if only he will apply to the responsible official, the house-surgeon, and not to any dresser, porter or nurse he happens to meet. We are sure many an unpleasant incident and many an apparent omission could be easily explained if the reporters and officials would interview the house-surgeons more and the porters and others less.

The position of a great charity like a London Hospital differs from a public institution in that, though we always take in any case that is moribund or dangerous, regard to limitation of space and funds, not to mention the feelings of other patients, prevents many cases being taken in. Who can admit to the society of respectable beings the awful drunken injured viragos and market porters who are brought up in custody very often, and we shall be sorry to see hospitals made the dumping ground of all troublesome "drunks" with scratches.

On the other hand, there is no doubt that the opening of the ward for observation only of concussions and other doubtful cases will save many an unpleasant incident, and we shall be very glad when the ward is ready for use. Still, the great tendency shown nowadays to expect the hospital for the district to take in unpleasant cases of all sorts loses sight of the object of its foundation, to minister to the wants and sufferings of the poor who are ill.

Among the many problems that the County Council attacks with unwearied zeal is the question of unnecessary inquests and expenses and the most important question of ambulances, and we expect confidently great and wise improvements in both these matters. For ourselves, we cannot deny the great work they do for those they govern and the ability and energy they display, though we often think it is a pity their spending powers were not limited by statute and they were more compelled to go ahead with caution.

There is not a doubt but that the law is the cause of so many unnecessary inquests. Inquests are held according to definite directions, and in well-defined cases the crux usually is death after a history of injury, especially in tubercular meningitis, and there is little doubt but that in most children in the Borough a fall is a certainty if the previous history is taken zealously, apart from the probability that the fall has occurred after the onset of the disease. So the wearied H.P. makes a diagnosis, records "tubercular meningitis post-mortem" on the certificate, and then finds that the zealous registrar has cross-questioned the mother for a fall, got an admission, and yet, in the face of post-mortem evidence, an inquest is held and money wasted, *cui bono?* If it had been a blow on the head, no jury could or would convict if the child had obvious old tubercular mischief, and yet explanation avails not, and an inquiry is held. It is the Law, not the coroner, and the Law is proverbially a "hass."

The automatic telephone is no more, that is until the new and improved service is erected, which we hope will not be long. There are few things which cause more inconvenience and trouble than a break down in the telephone system, and though the fusing of the wire and subsequent complete rapid destruction of the exchange-room only hastened the inevitable removal of the system, still it splits the wards of the hospital suddenly in its splendidly isolated units.

The Warden with ready resource determined the College should not bear the reproach of being the obstacle to the summoning of Residents, and equipped a hardy and ubiquitous Borough boy with a seat in the surgery and a post that is partly that of a Mercury and partly that of a Cinderella cleaning the irons. But for his sudden development of a septic throat the innovation has answered well. Mr. Barnes with remarkable ingenuity improvised from the wreck of the machine connections between the trunk wires, and within ten minutes a telephone which is still working without a hitch between the Surgery and the College and a call to the bathmen were in order, an exhibition of handiness and skill rare among landsmen.

The Rugby Fifteen achieved a notable triumph in the middle of last week on its visit to Oxford to play the Dark Blues. It is an ancient fixture that had lapsed, and we hope will be revived, as it dates from the foundation of the Rugby Union, when but few clubs took part, and but few are still in existence. The Cambridge, the Blackheath and the Oxford matches of the past, dated from that period.

A prominent member of the Oxford Fifteen estimated that the University would take about thirty points off Guy's on their own ground, in the absence through injury of both our half-backs O. V. Payne and M. G. Louisson; but the remarkable speed and skill of O'Brien and our redoubtable outsides, completely upset the Oxford Fifteen, and we believe, one of the heaviest defeats they have ever experienced, twenty-four points to eight, was the result.

Without wishing to triumph, we cannot help comparing the facility with which the 'Varsity three-quarters find their way into International Fifteens, though they may, and often do meet better opponents in club games. The superiority of our three-quarters over Raphael and his colleagues was undoubted, and yet we fear that our three-quarters have but scant chance of recognition, though England's need is sore.

It is not too much to say that Teddy Morgan, whose football was developed mainly at Guy's, would never have had the slightest chance of being an International had he been an Englishman, although he was a member of the victorious Welsh Fifteen and presumably would have been worth his place in an English team.

All who watch Hospital Cup-ties and then see English fifteens beaten forward in Internationals, wonder why no attempt is made to pick out some of the splendid forwards one sees and make use of them. We ourselves have not had many individual forwards who ought to have played, but some very smart forwards have been at other hospitals who were at least worth a trial, notably St. Thomas's in the past and St. Bartholomew's and elsewhere.

We do most heartily congratulate the Association on their victory over St. Mary's, the Cup-holders, against whom Fate has thrown us much in the last four years, to our detriment be it added. We have had good teams, but want of dash and that indescribable go and vigour that is essential to Cup-winners, and is rarely seen in any but stout-hearted players. We trust they will fight out the ties they have yet to go through with as successful results.

The Debating Society is not dead, as it might appear from its present inaction, neither does it sleep. The regretable discrepancies between promise and performance, are due to a succession of those unavoidable clashings, which beset all secretaries anxious to make and keep a fixed programme as regards dates, in a naughty world. The present somewhat lengthy gap is rather the lull before the storm, which is due to break, in the Smoking Room, on February 28th, when a veritable battle of giants will occur between Messrs. Thompson and Hodgson, as to the merits and demerits of "The Little Corporal."

Thl Dental Society hold their Eighth Annual Dinner at the Trocadero, on Saturday, February 21st, at 7 p.m., under the Presidency of Percival S. Campkin, L.D.S. The dinners have a deserved high reputation for popularity, attendance, and success, and those who miss the chance of meeting their friends will we are sure regret it. The energetic Secretary, Mr. A. D. Crofts, has notified and published the fact in every conceivable way, but as a reminder we print the fact again. If the dinner reaches half last year's success all will be quite satisfied, and we learn that the musical arrangements are in good hands.

The strife and newspaper warfare about the Bart.'s appeal has resulted in the appointment of a strong committee to report fully, freely, and finally on all matters they think desirable in connection with the appeal. It is impossible to quarrel with the decision, with the policy of enquiry, or with the names and standing of the Inquisitors. Among the latter we are pleased and proud to notice the name of Dr. P. H. Pye-Smith, M.D., F.R.S., who, after a long and distinguished service at Guy's, and many years service as Senior Physician, recently, to our regret and loss, joined the Consulting Staff. He has since done much useful work for the University of London, and has represented this country at the International Congress on Tuberculosis.

We congratulate Dr. Hale White, Mr. Steward, Mr. Badcock, Mr. Maurice Craig and Dr. Dakin, on their appointment as teachers to the Military Central Hospital shortly to be opened on the Thames Embankment. Dr. Dakin will be remembered as the author of the Guy's Charity's Heraldic Arms and Representation, as well as for his reputation as an author and consultant. The teaching will be quite safe in their hands.

We have often received suggestions as to the matter of the GAZETTE which are often impossible—occasionally sarcastic—and not intended for publication. The enclosed we received, and finally decided to print, it had a peculiar fascination for us, the style seemed familiar, and finally we came to the conclusion (we are absolutely in the dark about it) that the writer had misplaced his initials, if so we appeal to him to write again and be more explicit:

"I have just been perusing the last GAZETTE in my lonely exile; and, as patients do not seem to find any fascination in the red lamp outside, have decided to send a few lines to you for publication or not as seems best. You ask for suggestions as to what the GAZETTE should contain. May I, for my part, answer—(1) More of everything, especially football; (2) More Nursing Notes and Chapel Notes; (3) That no Clinical lecturer be allowed to end "*I had intended saying a few words about treatment, but see that time does not permit of my so doing.*" I would like to point out that to most of us, Clinical Lectures are very interesting reading, and that if they are worth reporting at all they should be reported in full. It is most tantalising to read of various symptoms and then find no remedy is suggested.

"If you are short of news write a paragraph about the openings and fortunes of this golden city; they need not necessarily be true, but may induce some Guy's friends to come out to try their luck, in which case life would be less lonely with companions in adversity.

"What has happened to 'In Lighter Vein'? (This is not meant as a contribution to that column.) Do they still have Clinical lectures on Saturdays to keep away 'footer' men? Best luck to both Cups —keep 'em!—Yours sincerely,

"C. M. R."

"Johannesburg,
"January 3rd, 1903."

Mr. FREDERICK MARTIN, of Holmhurst, 27, Southend Road, Beckenham, who died on November 28th last, aged 73, bequeathed £1,500 to the Royal Medical Benevolent College at Epsom, and to Guy's Hospital.

DURING the past year alterations in the Borough have been completed which will change the place for old Guy's men who either lived there or tramped it thoroughly as externs. Close to St. George's Church are preserved the remains of the famous Marshalsea Prison, and on the opposite side of the road a slum has been turned into Little Dorrit playground. The new Nursing Home has not altered the appearance much. The County Council has driven a road straight from the Tower Bridge through slums to meet Bermondsey New Road, to direct traffic into the Old Kent Road. The entrance to Long Lane is being widened, and from St. George's Church to Crosby Row demolition of buildings are rapidly taking place. The County Council is building proper Coroner's accommodation on the Marshalsea Prison site.

MISS BRERETON, who most will remember better as Sister Bright, has been beguiling her time by lecturing on hospital work in South Africa during the war, with limelights. Her services at Deelfontein under Mr. Fripp, and afterwards at Pretoria, as well as her appointment as one of the Ladies' Committee on Refugee Camps, lend weight to all her remarks. We hope Miss Brereton, who is off to South Africa again shortly on more Government work, will repeat her lectures within our reach. We can promise a large and appreciative audience.

AN unusual case was recently admitted of a woman who had swallowed in her sleep her false teeth. They caused no inconvenience, but were located in the œsophagus by the X Rays but the patient sank after the operation. Several days had elapsed before the attempt to remove them. The plate was about the size of a half-crown with three teeth.

ANOTHER interesting case not worth reporting in full was intestinal obstruction and retention in a boy. A mass was found which enemata entirely failed to relieve. Under an anæsthetic the condition was relieved by a scoop, and found to be a mass the size of an ordinary porringer chiefly consisting of unmasticated almonds and nuts.

ANOTHER interesting case was one in which chronic obstruction was operated on and nothing found. The patient eventually died from a rupture of an unnoticed abdominal aneurysm. The case of a ward maid is fresh in all our

minds, but the details would not bear repetition in print, as the most extraordinary discrepancies in stating the case were found to exist after the diagnosis had finally rested on "hysteria," and we would not make enemies nor misrepresent.

SOME Guy's men kindly promised to help certain inmates of the French Protestant Hospital. The programme was much enjoyed, especially the recitation of Mr. Edridge and Mr. Black's bassoon solo, which created great amusement. The French Protestant Hospital holds a unique position. It was established in the seventeenth century by the wealthier Huguenots for the benefit of the poor brethren, chiefly Spitalfields weavers. Admission only is allowed after the sixtieth year, and strict Protestant descent from the Huguenots must be shown.

AT the Surrey Masonic Hall, Camberwell New Road, "Florodora" was performed by the Stadella Musical and Dramatic Club, by kind permission of Mr. Tom Davis, in aid of the funds of Guy's Hospital.

Pass List.

University of London. January. 1903.

INTERMEDIATE EXAMINATION IN MEDICINE.

ENTIRE EXAMINATION.—SECOND DIVISION.—E. H. Adams, T. H. Barton, R. J. Bentley, G. Hamilton, E. M. Harrison, H. S. Knight, E. F. Milton, T. C. Pocock, W. P. Purdom, F. A. Sharpe, H. A. Watney, F. T. H. Wood.

PHYSIOLOGY ONLY.—SECOND DIVISION.—I. R. Cook.

PRELIMINARY SCIENTIFIC (M.B.) EXAMINATION.

ENTIRE EXAMINATION.—FIRST DIVISION.—S. H. Cummings Air, E. L. W. Mandel, M. D. Price.

SECOND DIVISION.—H. R. Bastard, R. C. V. Edsall, A. L. Gardner, J. B. Martin, H. E. Perkins, S. G. Tracy.

CHEMISTRY AND EXPERIMENTAL PHYSICS.—M. E. Ball, *A. F. W. Denning, J. B. Dunning, *T. Evans, *H. J. Henderson, K. H. Hole, B. McDermott, *M. J. Rattray, *G. F. Syms.

BIOLOGY.—S. S. Brook, G. B. Harland, *D. Reynolds, *H. Joste Smith.

*These candidates have now completed the examination.

Final Conjoint Examination, January, 1903.

MEDICINE, SURGERY AND MIDWIFERY.—*A. R. Brailey, *C. B. Penny.

MEDICINE AND SURGERY.—N. Ivens Spriggs.

MEDICINE AND MIDWIFERY.—*S. Child, H. C. Winckworth.

SURGERY AND MIDWIFERY.—H. S. Jones, F. C. Robinson, B. H. Wedd.

MEDICINE ONLY.—*W. F. Box, J. C. O. Bradbury, G. L. Buckeridge, *W. H. Cole, H. M. Goldstein, *A. W. Iredell, H. C. C. Mann, F. H. Parker, W. W. Read, C. R. Shattock, *V. M. Wallis.

SURGERY ONLY.—*F. W. Fawssett, *L. S. H. Glanville, E. G. Goldie, E. Roberts.

MIDWIFERY ONLY.—R. G. Anderson, H. W. Bethell, J. S. Cooper, J. H. Donnell, *P. W. Hamond, F. C. R. M. Knight, T. C. Lucas, D. H. Richards, H. L. Shelton, F. J. Turner.

*Denotes completion of examination.

School Examination, January, 1903.

ELEMENTARY ANATOMY.—J. K. A. Holm, G. R. Phillips.

Notices.

ROYAL COLLEGE OF PHYSICIANS.

Lectures of the present year will be delivered at the College, Pall Mall East, on each of the following Tuesdays and Thursdays, at 5 o'clock:—

MILROY LECTURES.—Dr. H. T. Bulstrode, March 5th, 10th, 12th, "The Causes, Prevalence and Control of Tuberculosis."

GOULSTONIAN LECTURES.—Dr. A. S. F. Grünbaum, March 17th, 19th, 24th, "Theories of Immunity and their Clinical Application."

LUMLEIAN LECTURES.—Dr. T. R. Glynn, March 26th, 31st, April 2nd, "On Infective Endocarditis mainly in its Clinical Aspects."

(By order of the President)
WILLIAM FLEMING,
Bedell.

UNIVERSITY OF LONDON.

The Dean wishes to draw the attention of all Graduates who took their Degrees in 1901 to 1902, to the following resolution passed by the Senate:—

"That Students who graduated in 1901 or 1902, and who can submit certificates from a School or Schools of the University or from recognised Teachers,

to the effect that they have completed a full course of study for the Intermediate and Final Examination, extending in all over not less than two years, be granted a Diploma worded as those issued before the reconstitution of the University, and without reference to the distinction between Internal and External Students."

Guy's Hospital, February 3rd, 1903.

LONDON UNIVERSITY MATRICULATION.

The Dean desires to draw attention to the following resolution of the Royal Colleges of Physicians and Surgeons, England:—

"It has been decided that any Students who pass the Matriculation Examination of the London University in the Medical Faculty, shall be considered as having fulfilled the requirements of this Board so far as the Preliminary Examination is concerned for the commencement of professional study for the Diploma of M.R.C.S. and L.R.C.P."

February 6th, 1903.

What constitutes Albuminuria? A Query.

PICRIC ACID TEST.

In my hospital days at Guy's no routine mention was made of picric acid as a test for albuminuria. I have been noticing for some time that urines which would otherwise pass as sound under the ordinary heat and nitric acid test and the nitric acid test in the cold with standing time allowed, betray a cloudiness with picric acid and this in acid urines with varying gravities. Are we to condemn the urine and so the person whose urine repeatedly, or at repeated intervals gives a cloud with picric acid alone which boiling does not remove?

I believe I have read that the late Dr. Johnson who brought into prominence the picric acid test considered any trace of albumen to be organic, while our Dr. Pavy did not think so seriously of slight albuminuria.

I am writing of cases where nothing adverse is found microscopically and where the age may be over forty years.

In insurance work to write albuminuria against a client is serious, because should the client attempt to insure his life at another office this other office will ask for and obtain from the first office the medical report with the statement of albuminuria in it. In consequence the second office as well as the first will probably demand an increased premium. What I feel is that when otherwise an individual stands favourably the tests for good health, the picric acid test may come in and block the way and raise a doubt. How is this doubt to be met? The days were happier when we did not use picric acid as a urinary test!

A. WITHERS GREEN.

In Lighter Vein.

DISTURBANCES IN THE GUY'S OWN.

Startling Revelations.

Resignation of Promising Officers.

Bugler Br—ley's Evidence in Full.

Strong Action by Lord Kingswood Warren (Commander-in-Chief).

Cashiering of the Senior Colonel.

The disclosures of an extraordinary affair lends a lurid light to a lax life of lamentable luxury, levity and licence, led by the leading lights of our London legionary loafers.

[Copyright in England and America; patent applied for; and registered as trade mark in Germany. May be sung without fee or licence at Music Halls by kind permission of the *Daily Wail*].

The Hon. John Adkyns, of Brockley Towers, heir to Barony of Whatteau, in Norfolk, Bugler Brailey, of Trachoma Ireland, younger brother of The Hypopyon of Hypopyon, and Brown, of London, S.E., all promising officers, have been driven out of the army, because "their honour is not safe."

We, the *Daily Wail* (in the absence of "copy") compelled a War Office inquiry. The thanks of the Nation are due to Us for our noble and Patriotic conduct. Our circulation is five times as rapid as that of any other paper. Briefly, although no facts have transpired, and we have no information, we are in a position to state positively that their offences consisted in such minor delinquencies as sneezing in the trough at mess, refusing to wash when requested to by a majority, shirking the Regimental Cat-Hunt, and not "going round for fees" at dinner.

A crisis was reached when the Hon. John, who had been detached for Instruction in Physical Signs with the King Clinicals, was recalled to duty in such tones that the telephone exchange blew up. His Colonel, whose supinator longus was very stiff after a hard day's shooting, "handed him over" to the senior subaltern for a mock court-martial and sentence. A painful scene followed.

* * * * *

(SPECIAL TO THE *Daily Wail*).

At the official enquiry, at which the Commander-in-Chief, Lord Kingswood Warren presided, the Hon. John said he was a perfectly peaceful person, but somewhat stiff. When offered a seat, he said he preferred to stand.

Mr. Brown said nothing, but smiled feebly. He was severely cautioned.

Bugler Brailey deposed that he was really Cornet Brailey. He was called Bugler because he couldn't play the cornet. Cross-examined: it was true he had seen some service on Clapham Common, and was with the C.I.V.'s in their famous march to Nine Elms. The decoration he wore was the Ping-pong Championship.

The Senior Subaltern, Mr. Chas. Robson, was then called. He detailed the circumstances, and said he had thought the collapse would be fatal, and had given 10 mimins of strychnine before informing the Adjutant.

Captain and Adjutant Rose Bryant was then called. He deposed he had no personal knowledge of the matter, but had sent for Colonel Taylor (in command of the Second Battalion) expecting he would be involved too and probably be "shot."

Colonel Taylor, after consideration, thought the matter was a pure neurosis (sensation), but the tradition and the honour of the Regiment demanded its isolation.

Major-General Perripatetic (Officer Commanding the Home District) said that fortunately this was a very rare case. He thought it was an application dermatitis, and recommended Unna's paste.

Captain Hicks, who arrived from the G.P.O. on a motor mail van, said formerly he was a postman and not a soldier (applause), but now he didn't know what he was.

Orderly-Sergeant Eason, coming out of the sentry-box declared he was uncertain whether he was a commissioned or non-commissioned officer, but would back his brass plate against any in St. Thomas's Street. He was confident no "ragging" went on in the College, as he would certainly have been the first victim, since he had parted with Mr. Dunn's housekeeper.

The President said that there was evidently some misunderstanding. If all Subalterns would show the tact of Mr. Brown there would be fewer scandals. The Colonel had left the Court without the slightest reflection on his reputation as a man of honour and a soldier. If his papers were not sent in shortly he would be dismissed the service.

Mr. Hicks offered to take the papers to the post.

At this point, five minutes before closing time, our reporter left hurriedly.

BIRD OF PREY.

Examination Results.

THE results of the Preliminary Scientific and the London Intermediate are most gratifying. For the Preliminary 22 men went up for part or parts, and each man passed something, and for the Intermediate 13 out of 18 passed. Well may the Dean feel pleased. The standard of industry has notably risen in London generally of late years, at Guy's particularly; and that there has been a corresponding increase in the quality of demeanour among students and residents in the last five years, is undeniably the case.

Reviews.

The price of books submitted for review should in every case be stated.

Constipation. By G. Sherman Bigg. (Messrs. Bailliere, Tindall & Cox.) 2s. 6d. net.

This small, well printed work, deals with a familiar and obstinate complaint, and discusses dogmatically the question of the causation and treatment. It is a singularly unscientific publication and more homely and inaccurate than we like in a medical man of such position, *e.g.*: "The appendix is a small fluid tube which secretes an oil for the lubrication of the bowel." (Possibly, but still heterodox in our present knowledge.) "It is frequently asserted that this appendage is quite useless but . . . . it is unreasonable to conclude that any portion of the human anatomy exists merely for the production of disease or for the sake of removal by operation." There is a long list of prescriptions which may prove attractive.

The Surgical Treatment of Ulcer of the Stomach. By C. Mansell Moullin. (John Bale, Sons and Danielsson.) 2s. 6d.

We have rarely read a monograph of such present interest. Imperfections it has and omissions. It gives little light on causation or on prognosis, and we think lays too much stress on the surgical as opposed to the medical treatment. But it is recent and enlightening. It puts the present position of operation for gastric ulcer fairly, clearly, and pleasantly. The account of the pathology is incisive and instructive. We recommend it to all operative surgeons and to all who need enlightenment on this interesting condition.

On Paratubal Hæmatocele. By W. Sampson Handley, M.S. London, F.R.C.S. Eng.

The title of the paper would be a mystery to even the etymological classical scholar, and when, early in the paper, the distinction is drawn between this and peritubal hæmatocele, the ordinary man may well feel confounded. Perimetritis we know and parametritis, but these two do not follow the same line, though probably the derivation is more strictly correct than either the older homologues.

Peritubal Hæmatocele is not a hæmorrhage around the tube, but an encysted blood effusion escaping from the end of the Fallopian tube, and paratubal hæmatocele is the explanation of an obscure case and the title of cases of ruptured extra-uterine fœtation in which the tube is pervious, because the mole or extra-uterine product has escaped through a rent and the rent has closed leaving the extra-uterine fœtation encysted alongside the tube. A glance at the pamphlet, which may be found in the library, will make the point clear. We congratulate Mr. Handley on an ingenious discovery.

Sport.

Rugby Football.

GUY'S v. BART.'S.

Inter-Hospital Cup-Tie.

Great interest was taken in this cup-tie, played at Richmond on Tuesday, February 10th. The day was an ideal one for football, and the ground in excellent condition. A large and enthusiastic crowd witnessed the encounter.

Guy's having lost the toss, Tolhurst kicked off from the entrance end, and play opened in Bart.'s territory. From the second scrummage of the game, Cutler got the ball smartly away to Morgan, who, after an excellent run, enabled Alcock to score far out. O'Brien failed to convert. From the drop-out the Bart.'s forwards carried the ball to half-way, a fine tackle by Orpen stopping the rush. A long kick by Harrison, and good footwork by Saunders, led to Guy's looking again dangerous, but a kick for foot up brought relief. McEvedy essayed to drop a goal, and Bart.'s touched down. The Bart.'s forwards, carrying the scrums, transferred play to Guy's twenty-five, and some exciting play was witnessed, a beautiful kick by Morgan to Bart.'s twenty-five bringing relief. Alcock, after a strong run, almost scored. Immediately afterwards O'Brien passed out to McEvedy who, on reaching the opposing full-back, transferred to Morgan, enabling him to run round and score behind the posts. O'Brien converted. From the kick-off Harrison knocked forward, and a scrum on Guy's goal line resulted. Good forward work, in which Thompson, Anderson and Glendinning were conspicuous, relieved. McEvedy and Morgan found touch with useful kicks. Saunders and Pinching were good from the line-out. From half-way O'Brien broke through in splendid style, and passed to Morgan at the twenty-five, the last-named, after a clever run, scoring far out. From a difficult position Tolhurst converted. Guy's twenty-five was again visited, following a kick for foot up, but sound play by O'Brien, Orpen and Alcock, carried the ball back to half-way. Half-time—

GUY'S ... 2 goals, 1 try (13 points).
BART.'S ... Nil.

On resuming, Guy's were soon pressing, a good bout of passing by the behinds resulting in Alcock running to Bart.'s twenty-five. Ward and Glendinning headed a vigorous forward rush, but a free-kick to Bart.'s neutralised matters. O'Brien found touch with a long kick, followed soon by a good attempt to drop a goal by the same player. Cutler, Morgan and Pinching showed good defence, and Harrison was called upon to save. A kick to Guy's relieved. Following a period of rather scrambling play, Thompson and Glendinning carried the ball over, but it was kicked dead. Orpen gained much ground with two good punts. At half-way Cutler, receiving the ball, punted high, and Alcock racing forward, gathered well,

and scored an excellent try behind the posts. O'Brien converted. Anderson, Thompson and Saunders dribbled to Bart.'s goal line, but a kick relieved. Guy's continued to press, and Harrison, picking up neatly, dashed through and transferred to Orpen, who scored after a smart run. A good attempt by Tolhurst to convert just fell short. A few minutes later Morgan raced down the touch line well into Bart's twenty-five, and being hemmed in kicked across, the race for the ball resulting in Saunders scoring far out. Tolhurst failed to convert. From the kick out McEvedy returned well into the twenty-five. Milsom headed a forward rush, and Orpen and McEvedy in turn tackled well. From some loose scrambling play the Bart.'s forwards carried the ball into Guy's 25 and scored far out. The kick failed. Soon after no-side sounded. Result:—

GUY'S ... 3 goals, 3 tries (24 points).
BART.'S ... 1 try (3 points).

Team:—

GUY'S.—E. M. Harrison (back); E. Morgan, P. F. McEvedy, L. J. J. Orpen, F. Alcock (three-quarter backs); A. B. O'Brien, F. Cutler (half-backs); R. G. Anderson, B. Glendinning, A. R. Thompson, E. L. Ward, E. H. B. Milsom, W. G. Pinching, A. M. Tolhurst, S. M. Saunders (forwards).

GUY'S v. KENSINGTON.

This game was played at Honor Oak Park on Saturday, February 7th.

Owing to the United Hospitals' match against Blackheath, and injuries, only six of our regular fifteen were available. A strong wind and heavy downpour of rain made good football impossible and considerably marred the pleasure of the small but enthusiastic crowd present. After a very scrambling game the Hospital retired defeated by 2 goals and 1 try—13 points—to nil. Team—

GUY'S.—R. D. Bridger (back); H. S. Brown, C. D. Pye-Smith, F. E. Walker, R. W. Allen (three-quarters); F. L. Cutler, E. C. Myott (half-backs); R. G. Anderson, W. G. Pinching, E. L. Ward, E. H. B. Milson, S. M. Saunders, A. H. Tolhurst, T. B. Layton, F. W. Hogarth.

GUY'S 3RD XV. v. EPSOM COLLEGE.

This match was played at Epsom on Saturday January 31st, and resulted in a defeat for Guy's by 3 goals (1 dropped) and 2 tries to nil. Harvey and Wight played a very good game. Team—

GUY'S.—H. N. Eccles (back); F. H. Wight, A. E. Kynaston, H. G. Gibson, G. Wacher (three-quarters); E. C. Myott, C. P. Harvey (half-backs); H. R. Grellet, J. Nunn, C. M. L. Cooper, L. Dowdney, B. B. Metcalfe, A. E. Dawson, D. Reynolds, L. L. C. Reynolds (forwards).

GUY'S 3RD XV. v. DULWICH COLLEGE 2nd XV.

This match was played at Dulwich on Wednesday, February 4th, in which Guy's was defeated by 3 tries to 1 try. Team—

GUY'S.—C. H. Marshall (back); F. H. Wight, J. Watson, J. Bookless, S. Reader (three-quarters); S. M. Stevenson, H. N. Eccles (half-backs); H. R. Grellet, J. Nunn, R. Willan (sen.), C. M. L. Cooper, B. B. Metcalfe, D. Reynolds, M. M. Adams, L. L. C. Reynolds (forwards).

Association Football.

GUY'S v. CASUALS.

This match was played at Honor Oak Park on Wednesday, January 28th, and resulted in a win for Guy's by 6 goals to nil. Guy's lost the toss, and kicked off against a strong wind. The ground was in a very muddy state, and at the start the game was of rather a scrambling order. Eventually Litchfield scored with a long shot, which, owing to a misunderstanding between the opposing backs, was allowed to roll into the net. Guy's continued to press, and Fothergill put in a good shot, which was saved, but Litchfield running up, easily scored. This was the score at half-time.

On restarting Guy's had it all their own way, and Litchfield scored again with a beautiful left-footed shot. Piper added the fourth, and Edey the fifth, while Litchfield scored the sixth.

Considering the state of the ground, our men played extremely well. Special mention should be made of Litchfield and Berry on the right wing, who combined beautifully. Team:—

GUY'S.—E. A. Collins (goal); A. G. Jones and A. D. Crofts (backs); P. C. V. Pedrick, A. F. Denning and A. L. Foster (halves); A. W. Berry, P. C. Litchfield, T. Edey, S. A. Piper, and C. H. Fothergill (forwards).

GUY'S v. CHESHUNT.

This match was played at Honor Oak Park on Saturday, January 31st. Guy's kicked off against the wind, and were quickly forced back into their own half, where play remained during the greater part of the game. Play on both sides was very ragged, combination being quite absent. Guy's forwards occasionally made futile attempts to relieve the pressure on their goal. Cheshunt scored once, by their inside right, before half-time.

In the second half Guy's commenced well, but collapsed later, and can scarcely claim to have seriously threatened the Cheshunt goal. Then the backs allowed a lame opponent to limp through alone, and score. Immediately after this Cheshunt scored again. Result—Cheshunt 3, Guy's 0.

REMARKS.—The nearness of the Cup Tie makes us view this match with dismay. Norton, Denning, Collins and Frankenburg were the only players who showed any skill. Jones, might with advantage strive to improve his kicking, instead of losing the ball by dribbling. Pedrick was much too slow, and showed great lack of judgment in his kicking. Fothergill made extremely feeble attempts to gain ground when he had the ball.

GUY'S v. MARY'S (Holders).

INTER-HOSPITAL CHALLENGE CUP.

This match was played in ideal weather at Chiswick, on Monday, Feb. 9th. Mary's won the toss and Guy's kicked off in the presence of a small, but enthusiastic crowd. Guy's at once pressed and shewed some good combination by Barber and Norton, the latter opened the scoring a few minutes from the start. On resuming, further goals were quickly added by Barber and Norton, the former scoring with a clever overhead kick. Nothing further occurred before half-time, the score standing Guy's 3 goals, Mary's nil.

On resuming Guy's continued to have the best of the play, and would have added to the score on several occasions, but for the efforts of their goal-keeper. After two successive corners, the ball came out to Pedrick, who banged it into the net. Shortly before the finish, the Mary's centre, after a fine dribble, scored their first goal. and the result was—

GUY'S	...	...	4 goals
MARY'S	...	...	1 goal

One of the features of the game was the great display by Denning at centre half, who has seldom played a better game. The forwards were quick on the ball and combined well in the first half. The backs were very safe.

GUY'S.—E. A. Collins (goal); A. G. Jones and A. D. Crofts (backs); A. F. Foster, A. F. Denning, and P. C. V. Pedrick (halves); A. W. Berry, P. C. Litchfield, H. Barber, E. L. R. Norton, and S. A. Piper (forwards).

GUY'S 2ND XI. v. WOODFORD ALBION.

This match, played at home on January 24th, resulted in a loss to the hospital by 7 goals to 2. Starting with one man short, and a weak team, we were soon hard pressed, and from a mistake made by our goal keeper Woodford scored. They still continued to press and quickly added another point. Peall then scored for Guy's by a good piece of individual play, and the absentee arriving, we held them in check for some time. By half-time our opponents had scored twice again.

Upon recommencing the game became more even, but the combination of the forwards was poor, occasionally on account of a desire to shine individually, and the passing of the halves was careless, although they tackled well, Perkins at centre putting in some useful work. Woodford added 3 points and Guy's 1 point, the result being as above stated. Speaking generally, the forwards need to combine better, and the halves to be smarter on the ball and more careful in passing. Team:—

GUY'S.—E. H. B. Turner (goal); A. Leeming, T. Wrench (backs); —. Scales, H. Perkins, C. H. Mills (halves); P. A. Peall, H. Miller, F. Morris, H. Barlow, and H. Clough (forwards).

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICE.

A. E. P., LOUGHBOROUGH.—This sputum contained a large number of tubercle bacilli, often in small brightly stained clumps.

PATHOLOGIST.

Papers by Guy's Men.

A Lecture on Chronic Obstruction of the Cæcum and Ascending Colon. Delivered before the Sydenham Medical Society, on November 20th, 1902. By W. Arbuthnot Lane, M.S. Lond., F.R.C.S.—*The Lancet*, 17th January.

The Value of Blood Examination as an Aid to Diagnosis and Prognosis. By J. H. Bryant, M.D., F.R.C.P. Lond. —*Lancet*, 7th February.

The Etiology of Acute Rheumatism and Allied Conditions. By R. M. Beaton, M.B., C.M., and E. W. Ainley Walker, M.A., M.D.—*British Medical Journal*, 31st January.

A Case of Extra-Uterine Fœtation. By T. H. Morse, F.R.C.S. Eng.—*Lancet*, 7th February.

On the Micrococcus of Acute Rheumatism. By E. W. Ainley Walker, M.A., M.D.—*The Practitioner*, February.

Births.

CARTER.—On January 27th, at Dartford, the wife of Arthur Burnell Carter, M.R.C.S., of a daughter.

CURRIE.—On January 3rd, at 18, Longmarket Street, Maritzburg, the wife of Oswald James Currie, M.B., M.R.C.S., of a daughter.

Death.

WILLIAMS.—On February 1st, at 5, Amhurst Park, Stamford Hill, Emily L. Williams, wife of Henry Williams, of Guy's Hospital, aged 46.

ED.—J. M. B.

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Calendar of Coming Events.

Feb., 1903.

Sat. 28.—Messrs. Symonds and Steward's take-in; Drs., J. D. Thomas and R. Franklin; Cl., C. R. Howard.
1 p.m., Clinical lecture by Dr. Taylor.
G.H.R.F.C., I., Marlboro' Nomads, away.
II., St. Thomas' II., home.
III., Old Charltonians "A" away.
G.H.A.F.C., I., Surbiton Hill, away.
II., Old Foresters II., home.

March.

Mon. 2.—Dental Appointment List opened.
1.15 p.m., Clinical lecture by Mr. Brailey.

Tues. 3.—Inter-Hospital Association Cup. Semi-Final. Guy's v. St. Thomas's.

Wed. 4.—1.30 p.m., Clinical lecture by Mr. Symonds.

Thur. 5.—Messrs. Lucas and Lane's take-in; Drs., P. P. Cole and A. V. Maybury; Cl., G. Evans.

Fri. 6.—April Appointment List closed.
Inter-Hospital Rugby Cup Match. Final, London v. Guy's. (Possible date.)

Sat. 7.—1 p.m., Clinical lecture by Dr. Taylor.
G.H.R.F.C., I., London Irish, away.
II., Wasps, away.
IV., Streatham "B" away.
G.H.A.F.C., I., Reigate Priory, away.
II., Clapham Rovers II., away.

Mon. 9.—1.15 p.m., Clinical lecture by Mr. Fagge.

Thur. 10.—Application to Medical School Office for Schedules for 1st and 2nd Conjoint Exams. to be made not later than this date.

Wed. 11.—1.30 p.m., Clinical lecture by Mr. Symonds.
G.H.P.P.S., Treasurer's Prize Essay on "The Pathology of Chorea."

Thur. 12.—Messrs. Golding-Bird and Dunn's take-in; Drs., G. A. Ticehurst and M. J. Mottram; Cl., H. S. Brown.
Dental Appointment List closed.

Sat. 14.—1 p.m., Clinical lecture by Dr. Taylor.
G.H.R.F.C., II., Borough Road College, away.
G.H.A.F.C., II., Central Technical College, away.

Guy's Hospital Gazette.

FEBRUARY 28, 1903.

On the treatment of patients with Consumption in the Open Air.

CLINICAL LECTURE BY DR. NEWTON PITT.

November 22nd, 1902.

GENTLEMEN,—Our views within the last few years have altered considerably as to the best way of treating consumption, and as to the influence of fresh air on the course of several diseases. We have had several patients during the past few weeks being treated on the balconies, and I wish to take the opportunity this afternoon of drawing your attention to certain details in the treatment of consumption, more particularly by fresh air.

I need not burden you with any great detail about the patients; I might rather, perhaps, summarise shortly the results of several. I must first impress upon you, that six weeks is not a sufficient time, in which to show any alteration in the physical signs, excepting when the patients happen to come into the hospital with some acute attack. It happens that many patients are admitted because of severe hæmoptysis, acute pneumonia, or an intercurrent bronchitis or pleurisy; in such cases the signs may alter quickly. When there has not been any such complication and a patient has been admitted simply for the purpose of benefiting the course of his phthisis, you will find that six weeks of treatment, while it may improve his physical condition enormously, will make but little difference in the physical signs.

I will bring before you more particularly to-day three cases of phthisis. They all have increased in weight. One was a man, aged 36, who was

admitted with well-marked phthisis. He was an alcoholic patient and the mischief was chiefly on the right side. He weighed 105 pounds when admitted in July, and six weeks later he had put on over 10 pounds in weight. His anæmia had diminished, his appetite and his general condition improved, and he was in a very much superior state of health, although the physical signs had not made any very great alteration.

The next case is that of a man, aged 20, who came in with well-marked phthisis at his right apex. He also has greatly improved, and his increase of weight between September 24th, when his weight was 110 pounds, and November 12th, was 11 pounds. The physical signs have not altered very much, but during this time his temperature has come down to normal and has remained so for some three weeks.

Taking the average of a large number of cases in sanatoria, the temperature comes down in about four and a half weeks. If a patient's temperature does not come down within two or three months of treatment, the probability is that he is not going to recover. In this particular case the temperature fell down to normal about the end of the fifth week. These temperatures I am speaking of, are, for the most part, mouth temperatures, and I will point out to you directly the fallacy thereby involved, and that the only reliable method of taking temperature, in determining whether it is really normal, is in the rectum. If there is any slight activity in the lung you will have pyrexia as shown by a rectal temperature, and yet you may have a normal temperature in the axilla or mouth. The most experienced sanatoria authorities insist that, to form a reliable judgment as to any case, it is necessary that the temperature be taken per rectum.

The third patient, a man aged 54, was admitted with evidence of mischief, not very advanced at the left apex. In his case also his weight has increased. Up to last week he had increased 12 pounds, but this week he has lost 4 pounds, so that the increase during the last six weeks has been only 8 pounds. There has probably been some little increase in the mischief this week.

I do not propose to go into further detail as to these cases, but will now discuss the general question as to the method of treatment.

The subject of tuberculosis is one of the most important that you can possibly have to deal with, because one-seventh of all the deaths that occur are due to it. In England, some sixty or seventy thousand die every year from tubercle; and in general practice, one of the most difficult problems is the question of dealing with those patients, who have chronic illnesses, which you have to control and regulate.

I need not enter very fully into the age distribution of the disease, as it is impossible in the short time at my disposal to attempt to cover the ground entirely. Your books will supply you with the well-known facts of the disease. I rather want to draw your attention to points which are not so very fully treated in books.

Tubercle is not a disease limited to the young, and the fact is often overlooked that the mortality from it increases with each decennium of life. This is due to the fact that the number of deaths at any age are not compared with the number living at that age. When this is done it is found that the death-rate per 1000 is between the ages—

0—19	...	·8
20—39	...	4·2
40—59	...	4·5
Over	...	4·5

I want you to notice that the liability to deaths from consumption in old people is very considerable, and that it is not less than that in young people. There are many more people living under forty years of age than over, and therefore the total number of deaths from consumption below forty years of age is very great. But in proportion to the number of people living at each decenuium the mortality does not decrease with age. This is not clearly brought out in books, and yet the same results are noticed both here and abroad. Of course, as people grow older the total number of deaths are very much greater, and therefore the percentage of consumptive deaths to other deaths diminishes considerably.

The percentage of deaths due to tubercle are, in men, as follows, at the different ages :—

1—19	..	24·6
20—29	...	42·8
30—39	...	35·1
40—49	...	21·0
50—59	...	11·1
60—69	...	4·9
70—79	...	2·7

I want to emphasise the fact that during the young, active, working life of the population, that is, between the ages of twenty and fifty, tubercle is infinitely the most important cause of death. Between twenty and twenty-four almost every other death is due to consumption; between forty and forty-four there is one death in four; between sixty and sixty-four there is only about one in twelve or thirteen. The proportion of deaths from tubercle, even in quite small children, does not exceed every other death.

Relation of tubercle to overcrowding.—As you know, it has long been pointed out that if you divide a town up into the crowded and less crowded populations—into those in which there are four or five living in a room, and those in which there are one or two living in a room—the consumption mortality varies with the crowding. If we take the proportion of deaths amongst people who live in the country and those living in towns, even in places where the country homes are far worse built than in towns, you will find that the mortality in towns is double, at least, that in the country.

Now the essential factor is the damage done to air by breathing it over and over again. If a room once becomes infected with tubercle bacilli and is not properly ventilated, the infection of the air becomes very marked. As to the effect of breathing on the air, we do not at present understand completely what changes are produced in the air from respiration. A certain amount of carbonic acid is produced. Still, if you put an animal into an atmosphere which contains a definite proportion of oxygen and carbonic acid produced by respiration, it is infinitely more deadly than if the same proportions of oxygen and carbonic acid were artifically mixed and the animal made to breathe it. There are, therefore, other changes which are very important. There is no doubt that if the same air is breathed a number of times, toxic changes take place. A simple way in which we can estimate roughly the quality of air is by the amount of carbonic acid it contains. In books it is generally stated that the normal amount of carbonic acid in air is 3·5 to 4 per 10,000, and that if the amount of CO_2 in the air is kept below 6, such air may be considered to be evidence of sufficient ventilation. There is no question whatever, that if you put a patient in an atmosphere where the carbonic acid is under 4 parts per 1000, and compare his condition with that when he is breathing in an atmosphere which contains say 6 parts per 1000 carbonic acid, the difference in the patient's condition is enormous. I have seen two or three very striking cases myself in this connection. If people carry out the open-air treatment at home and sleep with the window six inches open, you would find that the amount of carbonic acid in the morning was nothing like so small as if the window were half open. At Ventnor it was found that if patients were out in the open air altogether, the amount of carbonic acid was 3·5 per 10,000; if the window was half-open 6·4; if only an inch 7·3.

Dr. Walters has drawn attention to the fact that even with an open veranda if it is deep (say 12 feet high and 12 feet deep) and there is no ventilation at the top, the air in the morning will be distinctly stuffy. It is not sufficient to have a window open; it will make a great difference if there is also a free through ventilation. So that the conclusion is now gradually being arrived at, that in recommending a patient to adopt open-air treatment it is certainly not sufficient to half open the window. In Dr. Walters' cases, with half open windows, the patients were constantly getting cold, but as soon as the windows were taken out the catarrhs ceased and there was a general improvement.

He has shown that in cases where patients sleep with only the window open, their improvement is nothing like so great as when they sleep with both windows and door open. To give the best results a thorough current of air is necessary,

hence a sanatorium should be a long narrow building with no trees near. The idea that it is injurious to be in a draught is shown to be a fallacy, provided you leave a large open space and not a narrow chink. If you have the door and windows wide open you will find the patients improve very much more than if only the window is open. The following observation suggests the explanation. A patient was sleeping in a room with a cubic capacity of 1100 feet, and when the window, which was large (fifteen square feet) was open, the amount of carbonic acid in the morning was 4·8; when the window was only open five square feet, the amount of carbonic acid was 6·2; but when, in addition, the doors were put open the amount of carbonic acid fell to less than 4, and the patient improved more rapidly. It is almost impossible to keep the amount of carbonic acid in a room down to that in the outside atmosphere without a free current. Merely having the window open is not sufficient, and patients therefore who sleep on balconies do much better than in rooms, and people in rooms do much better if they have both door and window open. Hence the great importance which is being insisted upon, that sanatoria should be built only one room deep so that all can get a full current of air. If you have a corridor and rooms on each side you do not have the same free current. For the same reason it is most essential to have no trees close to the house. If trees shut in houses either at the back or front, they prevent a current of air passing through the house. If the air is still, in our immediate neighbourhood, we breathe vitiated air. The great discovery which has been made, and is gradually being appreciated and generally accepted now, is the fact that the essential thing to do is to arrange that patients shall breathe unvitiated air.

If the amount of respiratory CO_2 in a room does not exceed 2 parts per 10,000 it is usually accepted as well ventilated.

If a free current of air be allowed to pass through the room the amount may be kept below 1; and this should be our ideal standard. Yet no protest is raised by the authorities against the incredibly foul atmosphere in the Central London Railway where the amount of respiratory pollution raises the amount of CO_2 to 15 parts and it has been stated even up to 20, an amount of pollution more than double that which is illegal in the foulest factory in the kingdom. For the past twenty-five years the British public have been sufficiently educated to be disgusted at the idea of drinking human excreta with their water, but they inhale human respiratory excreta with the greatest complaisancy.

We have educated the public to realise that it is injurious to drink human excreta; we have now to convince them it is still more injurious to inhale respiratory and cutaneous excreta.

Respiratory sewage is more deadly than renal and fæcal; the deaths from phthisis alone far outnumber those from typhoid, cholera, etc.

The infection of places.—I think that we may lay it down as a fact that CONSUMPTION IS A PREVENTABLE DISEASE. The fact that the improvement in sanitary conditions has reduced the total number of deaths from consumption in England during the last thirty or forty years, to at least one-half of what they were, shows how much has been done. The enormous improvement that takes place when people live in an entirely unvitiated air shows much more may be done, so that consumption can certainly be prevented.

Then we may also say that CONSUMPTION IS CURABLE. Of course, no disease which produces degeneration or destruction of any tissue can be strictly said to be curable, because it leaves at least a scar. But every process, even if it leaves no scar, leaves its mark, and the body is never the same as before; a good example of which is in the immunity which follows specific fevers. Still, so far as the physiological life of the individual is concerned disease may be cured. As evidence of my thesis I may draw attention to the fact that in the post-mortems in the hospital you find at least 10 per cent. of the bodies who have died of other diseases have evidence of cured phthisis. On examining the bodies brought into the Morgue at Paris it was found that over 20 per cent. of them showed more or less marked naked-eye evidence of tubercle, and in 60 per cent. of these the tubercle was obsolete, that is to say, the majority of them

were practically cured. But careful post-mortem examinations in recent years have shown that tubercle is really much more common. If you not only look at the naked-eye appearances in the lungs, but cut up the glands and stain them for tubercle bacilli, you find the proportion very large. The most striking statement yet made is by Dr. Nägeli, in Virchow's Archiv for 1900, who examined five hundred consecutive post-mortems in Zurich, and found definite evidence of tubercle in 97 per cent. of the total, and in 99 per cent. when over thirty years of age. That is practically, every single adult body gave evidence of tubercle. Every individual living in a town has undoubtedly inhaled tubercle bacilli at some time or another, and their remains are stored away in his body. On the other hand, it is only in a certain number of persons that tubercle bacilli flourish. It has been suggested that probably one-third of all adults have tubercle bacilli, which, if the individual get into a bad state of health, might very well light up. If these statements are true, they must very much alter our view of the disease and emphasise the idea, that the tubercle bacillus is not the sole essential factor in the production of phthisis, that a more important factor is the inability of the individual to fight against tubercle, to digest it and to flourish on it. If tubercle is so ubiquitous, then to deal with the physiological conditions of the individual is the essential factor in the treatment of phthisis. We may go further and say that every disease is due to a concomitance of two or more causes. At the present time many of us have pneumococci in our throats, but the probability is that none of us during the next month or two will have pneumonia. But break down your protective mechanism and the pneumococci may flourish and produce the corresponding disease.

The influence of fresh air on tuberculous patients.—I have pointed out to you that in order to obtain the best results you want a complete not a partial ventilation. The question arises whether wind itself is injurious. On that there is still a divergence of opinion. I myself believe very strongly, that it is most undesirable for a patient with a tendency to consumption, to live in a place which is subjected to storms and great irregularities in barometer pressure. Some very interesting observations were made many years ago by Dr Haviland, on the distribution of consumption in the north of England, in association with the tempestuous character of the weather at various places. Recently the same question has been reconsidered by Dr. Gordon for Devonshire and Cornwall; and it has been pointed out that the villages which have a high consumption mortality are those exposed to wind. One explanation has been offered which perhaps cannot altogether be rejected, and that is that where it is very windy, you probably keep windows and doors more shut, and therefore the rooms become more stuffy. But I doubt if this is a sufficient explanation. I have been very much struck at Seaford, on the south coast, where the majority of the people enjoy most excellent health, that many consumptive patients do badly. The place is much exposed to wind and storms, and the experience of the doctors at the convalescent homes is that active mischief often lights up quickly in consumptive patients who come there. I cannot help thinking that the tempestuous character of the place may have something to do with this. So that while I would emphasise the importance of thorough ventilation, I should not advise consumptive patients to go to places exposed to gales.

Undoubtedly sunshine is of enormous importance. Still it is not nearly so important as efficient ventilation. Dust also is a most injurious factor.

So that the three factors we should try to avoid in selecting a place for a consumptive patient are *deficiency of sunlight*, *gusty weather*, and a *dusty atmosphere*.

Now what are the results of taking a patient with early phthisis and putting him in a thoroughly well ventilated atmosphere and keeping him in bed. I shall refer to this last more fully later, because it is so essential in an active stage of phthisis that patients should be kept at rest in bed. It is simply extraordinary to see what a revolution in the appearance of a patient will take place under these conditions.

First of all the patients have been accustomed to be wrapped up, with respirators and great coats, and to live in hot rooms. They go down to a sanatorium, and without any acclimatisation at once start open air life, and it is found that no injurious results at all follow. If the patients are kept in the open air, although they may feel cold and chilly for the first few days, they are not liable to develop catarrh, pneumonia, or other complications which are generally put down to exposure. The first result, I should say, is the *disappearance of the liability to catarrh.* If you go to a sanatorium you will be astonished to see how *very little coughing* there is, and how very little the patients suffer from catarrh. The liability to nasal and bronchial catarrh then will quickly disappear.

It is, however, essential to keep a sanatorium free from infection with influenza. A visitor with influenza may start an epidemic which will run through the household, and allow many cases of quiescent mischief to light up.

The cough, of course, persists much longer because the expectorations, if breaking down is taking place in the lung, must necessarily be brought up, and consequently coughing will be necessary. At the same time the irritating cough so common in phthisis, when it is not due to expectoration, will very quickly disappear in the course of two or three weeks. *The patients quickly become acclimatised to cold.* It is very striking, in some hospitals which are kept with the windows widely open, that the patients themselves will object to the windows being shut, while the nurses, accustomed to sleep in their own rooms, will find the wards cold. It is quite a fallacy to suppose that it is necessary to keep rooms up to anything like the temperature that we generally keep them at. The air cannot possibly be too cold for these patients—I am speaking of the climate that we have in England—but it is necessary that they should have sufficient bed clothes, or if their circulation is defective, a hot-water bottle to keep their bodies warm. If their bodies are kept warm there are no bad results from the cold air they may breathe. On the contrary, if you warm the air you find that the patients do not do nearly so well, and it is much more likely that they will then complain of cold feet than if the room is warmed by a fire, or, if the patient is in bed, is kept warm by the clothes. As a general principle one would say, if you warm the rooms at all, warm them with an open fire. Do not warm them with radiators as the hot air then is most unsatisfactory. Tuberculous patients improve more in the winter than they do in hot summer weather.

Later on the anæmic appearance of these patients begins to disappear, *they recover colour*, and the *pulse slows down.* In many consumptive patients their pulse is rapid, but within a fortnight, as a rule, the pulse begins to slow down. If in any case, at the end of a month, the pulse has not begun to slow down, it is an evil sign in prognosis.

The *appetite* improves. Patients who go to sanatoria with a feeble appetite will soon enjoy their food, so that the amount they eat is very much above the average, and they are able to assimilate more, owing to the fact that they require more calories to keep up their temperature than if they lived in hot rooms.

The *chilly, shivery sensations* of which these people hitherto have complained quickly *disappear.* The *night sweats also cease.* It has been shown that if a patient continues to have night sweats there is probably something exceptionally wrong. Either the treatment is insufficient or there is some special complication. Patients whose night linen has been changed four times in the night very often, after having been at a sanatorium three or four weeks, will sleep the whole night without any uncomfortable perspiration.

They will *increase in weight*, and the increase is generally pretty constant until the weight reaches the normal, and in many cases even above the normal. *Insomnia disappears.*

Another curious thing has been noticed, patients who have been subject to *migraine* all their lives, entirely lose their migraine so long as they adopt open-air treatment.

Now comes the last and one of the most important points—the question of the patients' *temperature.* The temperature, when there is active disease, is usually raised, and the rule in sanatoria

is that a patient should be kept in bed as long as the morning temperature is above 99°—I am speaking of the rectal temperature. If a person takes exercise, even in health, the rectal temperature is invariably raised. It is a very interesting observation that in health, if you run, take a bicycle ride, or sharp exercise in any form, your temperature, taken in the axilla, may be perfectly normal, while the rectal temperature may be up to 102° or 103°, if the exercise has been very sharp; but very constantly it is up to 100° or 101° even in people in health. The failure in treating phthisical patients at home almost invariably is due to the fact that they are allowed to do too much. The rule should be, that every patient when coming in from exercise should have the temperature taken in the rectum, and if it is above 100·5° then it is clear that the amount of exercise has been too much for him. The temperature will always be as high as 99° or even 100° in phthisical patients after exercise, but that need not worry you. But if it goes habitually above 100·5° then the patient is doing too much. In this case you should keep the patient in bed, and keep him there until the temperature is down to 99° per rectum. Then, when you allow them to go out, you will see that at first they walk only a few yards, and increase the distance each day according to their returning strength. If you allow the patients to overtire themselves you certainly will induce an increase in the mischief in the lungs. It is for this reason, and also because, at present, it is quite impossible to persuade friends that it is not injurious to have both window and door open, that it is perfectly hopeless to attempt to treat the patients at first in their homes, and the only thing is to insist on their going to sanatoria where they realise the improvement that everyone is making under the conditions of open-air life, and the importance of regulating their exercise by its effect on their temperature. When they are once impressed with that, if they are sensible people, they may return home, and however their friends may tell them that it is injurious to have the doors and windows open they will not be persuaded to keep them shut.

The question of amusement is a much more difficult one. Doctors vary very much as to what they will permit. There is no doubt that most patients with phthisis will have their temperature raised if they enter into any discussion and become excited. Therefore it is found essential in these sanatoria that patients should not be allowed to congregate and that no exciting discussions should be allowed, and they should be kept very quiescent at first. But in some sanatoria that is perhaps overdone, and patients are idling about all day long with nothing to do. There is a happy medium which must be adopted in each individual case. There is no doubt that the amusements of photography and gardening, and quiet games, are of great importance in many cases. In many cases also it is most desirable to keep the patients' friends away from them. If patients get excited and have their friends beside them in the early stages of the disease, their temperature generally runs up.

With regard to the rooms, as to how much window space is desirable, in many cases there is no doubt that it is far better to let the patient sleep out of doors under a veranda. But if they are indoors it is important that there should be at least twenty-five to thirty feet open window space in the room. Where the rooms have specially been built for the purpose so that the windows can be taken out, that should be done, and they should be replaced when the patient is dressing. Otherwise they should be kept out altogether both day and night.

The question of food is rather a large one, and I will leave it, together with that of the early recognition of phthisis, for another lecture.

Papers by Guy's Men.

Is Rupture of the Aortic Valve an Accident under the Workmen's Compensation Act? By Theodore Fisher, M.D. Lond. Illustrated.—*British Medical Journal*, 21st February.

A Clinical Lecture on Exophthalmic Goitre. By W. Hale White, M.D., F.R.C.P.—*Clinical Journal*, February 25th.

Some Points in the Mechanics of the Jaws. By W. Arbuthnot Lane, M.S.—*Trans. of the Odontological Society* for January, 1903.

A Nervous Case presenting curious symptoms and terminating fatally in "Ingravescent Apoplexy"

A MAN æt. 58 years came to me complaining of giddiness and weakness in the legs when walking. He had been suffering from these symptoms for two months before consulting me. He says he had four years ago an attack of "blood vomiting," but this was not severe, and he soon recovered from it. But for the blood vomiting he has always enjoyed perfect health, and has always been steady, drinking but moderately. He gives no history of syphilis, nor can any trace of the disease be found.

On examination his nervous system presented the following symptoms. There was a slight loss of power in both legs, and when walking the patient showed no signs of ataxic gait, and he had good co-ordination of movements generally.

Over the outer side of each leg was an area of anæsthesia extending from the knee above to the ankle below, and bounded externally by a line drawn from the head of the fibula above to the external malleolus below, and internally by a line drawn from the tubercle of the tibia to a line drawn midway between the external and internal malleoli below.

This area of anæsthesia was identically the same in extent each leg, and was completely anæsthetic to pinching, and also to the introduction of a needle. The knee-jerks were absent in both legs and no ankle clonus or plantar reflexes could be obtained.

There was no wasting of muscles. Electrical reaction was not tried. Bladder and rectum were normal. Argyl-Robertson pupil and Romberg's sign were both absent, but over the anæsthetic area, on trying sensation to heat and cold, heat could be felt but cold could not. The skin over the anæsthetic area was shiny and glossy.

The heart showed signs of slight dilatation and hypertrophy, the impulse was in the fifth left intercostal space, about half an inch from the nipple line, the area of cardiac dulness extended up to the nipple line, but was normal above and internally.

At the apex a soft blowing systolic murmur was heard, but this was limited to the apex and could not be heard in the axilla or behind at the angle of the scapula. At the base a sharp second sound was to be heard in the aortic area.

The pulse was regular and easily compressible and was beating at the rate of from 70 to 80 per minute. The radial and temporal and other arteries showed no signs of degeneration or tortuosity.

The temperature was always normal.

The urine was clear, acid, and had a specific gravity varying from 1016 to 1020, and a slight albumen was sometimes found, but blood sugar coats, etc., were never found in spite of repeated examinations.

The alimentary and respiratory systems were normal.

The patient had been under my care for about two months and during this time the above symptoms remained practically the same as when I first saw him, except that on one or two occasions I thought he had some slight œdema at his ankles. He took his nourishment well and could digest practically everything; but he was kept to fish, chicken and milk diet as he had rather a craving for food.

On Nov. 19th (1902) I was called to see him at 8.30 a.m. as he was so restless. I found he had passed a very restless night up till 5.30 a.m., when he complained of a slight head-ache, this gradually got more and more intense and when I visited him I found him sitting up in bed holding his head between his hands and crying out with pain; he said the pain was "cutting and darting all over the top of his head." In spite of his agony he was quite sensible, after a few minutes he complained of pain and weakness in the right arm, this arm slowly slipped down from his head, and at the same time slight twitchings began in the right hand and fingers, and also in the right leg, and there also seemed to be some spasm of the jaw and neck muscles. The twitchings gradually became more and more frequent and the patient's speech became muffled. The face now was a pale ashen colour, both eyes were getting deviated to the right side with occasional nystagmus like movements and both pupils markedly dilated. The pulse was full with much increased tension. The breathing got more and more stentorious, and the pupils became gradually more contracted until they were quite "pin's point," the eyes now gradually came back to the middle line; the whole aspect of the patient changed to almost an inky black colour and breathing gradually stopped. The temperature was taken immediately after death in the right axilla the thermometer registered 100°, and in the left 104·6°.

I thought I would report this case as it may be of some interest to your readers.

The nervous symptoms which the patient presented do not seem to correspond with those of any nervous disease I am acquainted with. I suppose the patient had chronic interstitial nephritis, but the examinations of the urine never revealed any different result from that shown above, the albumen was only found twice in many specimens examined. The termination of the case in ingravescent apoplexy is interesting, for I think this may be claimed to be a very good example of that peculiar ending.

I suppose the hæmorrhage started in the arm area of the cerebrum, and it must have been a large one bursting through the brain subscance and gradually invaded the pons. Unfortunately an autopsy was refused, otherwise some light might have been thrown on a case presenting the above difficulties.

ERNEST E. CLOWES.

Wotton-under-Edge.

Fragments.

I have had to deal with some real "pieces" in the last few months which I think are of sufficient general interest to deserve publication. With another medicine-man (Dr. Hendriks) I saw a yeoman recently returned from South Africa. His horse had kicked him over the left external superciliary angle, inflicting a wound which had taken some weeks to heal; presumably, therefore, the wound suppurated. The man was invalided home for intractable headache, and had reached England sixteen days before we saw him. He lay curled up against the wall, and was unwilling to talk. He had been sick once; his temperature was 102°; his tongue was furred; his bowels constipated. His headache was intense, and the tenderness about the scar on his forehead was very great. Now note that his pulse-rate was only sixty. There was no albuminuria, nor optic neuritis. Cerebral pressure probably due to an abscess beneath the scar on his forehead was the diagnosis.

Next day he was less drowsy, but the pulse-rate was only 56. Headache as before. We began to consider the advisability of trephining, and took down and marked the dusty skull and polished the rusty trephine. Next day the symptoms were unchanged; on the following day a pink spot occurred on his abdomen. His enteric attack was severe, but uneventful.

A little while ago I was called to a very fat, elderly woman who had been drowsy for three days and was now nearly comatose. She had been a "tippler." There was albuminuria and aortic disease. I prognosed death in three days, and sure enough on the third day she was dying. That evening she rallied, and was fairly well for a week. Again the coma supervened, and again she was dying with a pulse "all over the place." She rallied once more; eventually she succumbed on the twenty-fourth day of her illness. I had made myself extremely rediculous by my prognosis, but I do not know how to avoid these errors. In "private" one must be fairly definite.

The resistance to death offered by some men is almost incredible. A youth of twenty-two years, previously recovered from a very severe attack of pleuritic effusion which sadly crippled his right chest. I had now to perform tarsectomy for tubercular disease. He was doing well, when he gashed his hand shockingly on some broken glass. In spite of all precautions the wound suppurated furiously, and he narrowly escaped death from septicæmia, recovering with a hopelessly crippled hand. He had now staved off the assault of the tubercle bacillus on two occasions, and of the streptococcus once. I was just congratulating myself on the issue of the last contest, when the pneumonia diplococcus seized him, and I left him at midnight on the second day with an uncountable pulse and in an unconscious condition. He fought death for the next four days, and then succumbed after a most heroic battle.

Here is an instance of "real hard lines." A lad considerably improved in his hearing after scraping out his naso-pharynx. Seven months later he went mad with auditory delirium, and had to be sent to the asylum. The folk declared that I had "touched his brain."

Here is a little warning about "fluctuation." I came a cropper; my experience may help others. A little girl had a "sore head," with inflamed occipital glands. One was very red and angry and "fluctuated" freely. I insisted upon incision. The mother refused; I became the more determined. I was wrong—it was not an abscess. Put a large marble under a blanket, press on it first with one finger then with the other, you will obtain perfect fluctuation. I had rolled a large hard gland to and fro beneath the scalp.

V. P.

Correspondence.

To the Editor of Guy's Hospital Gazette.

The Guyoscope.

Dear Sir,—Myself one of the "vivacious and scattered" authors of the late *Guyoscope*, I despair of finding words adequate to express the joyful pride with which I read a certain paragraph in yesterday's Passim. I refer, of course, to that setting forth the request for missing copies of the *Guyoscope*, addressed to you by the Bodleian Library. Your appeal for help shall not go entirely unheard, and I enclose my only duplicate copy for the benefit of that venerable and (I believe), respectable institution.

Is it mere coincidence that this zeal for the virile and the actual in modern literature is evidenced at a time when Oxford is being shaken from her muddy bed of hoary tradition, when new life is to be breathed into her ancient frame by the influx of breezy young manhood fresh from the prairie and the veldt, the sjambok and the blatwurst? There can be but one answer.

Truly do I puff myself with honest pride. At least I did until I read in another column that "the quality of demeanour among residents and students in the last five years" has "undeniably increased."

It is now 1903; the *Guyoscope* breathed its last in 1898.

By the way, I suppose you mean that the quality of demeanour has improved? I will not press the point. In my case it is a beautiful thought; perfectly sweet, I call it.

In conclusion, permit me to remark that I may or may not be "vivacious,"—I have my own opinion—, but, in justice to my friends, I most emphatically protest against being described as "scattered."—I have the honour to remain, sir, yours obediently,

Feb. 15th, 1903. "C."

[The last Gazette broke a record in the quantity if not the quality of Passim. The strain thrown upon our resources led to some paragraphs being hastily put up and appearing without correction. This accounts for the substitution of "quality" for "gravity" a phase which is more truthful and has more point.—Ed.]

A Case Presented at the Guy's Hospital Physical Society.

February 25th, 1903.

I HAVE been asked to bring a presumably interesting case before you to-night. I shall, then, with your permission and attention read you the notes of a *case* of a man, aged 47, which although diagnosed as a case of primary kidney disease with only heart changes, yet presented some marked equivocalities before death; and in whom the chief morbid change *after death* was discovered to be a largely hypertrophied left ventricle.

Time will not allow me to go into the history and symptoms of this case as fully as I should wish, and you must take it for granted that I shall state you the history and symptoms of the case in as laconic — although, perhaps, unorthodox—a manner as is compatible with the idiosyncracies of the aase. His personal history is noteworthy. He had typhoid fever at 22 years of age, but he never had rheumatism or gout. Sixteen years ago, when he was 32 years old, he was admitted to this hospital for cerebral hæmorrhage *supposed* to have been *caused* by a considerable fall from a height. No history of syphilis. According to his own account he has been practically a teetotaler for the past sixteen years, *i.e.* since the fall, which by the way happened when he was drunk. Previous to this nothing is known of his alcoholic history.

The Clinical tells me that while patient was under his charge, that he considered he showed an abnormal craving for his evening whisky. On admittance dyspnœa was marked and remained so.

With regard to the diagnosis of chronic interstitial nephritis, I wish to call your special attention to the state of the urine.

On admission the urine was found to be loaded with albumin; sp. gr. 1020; and was normal in quantity.

Later on the albumin was scarcely perceptible and only remained as a trace for about a month before his death. But some tube-casts were now found and there was during this time a large quantity of urates, with progressive diminution of the amount of the urine.

Mr. Ormond examined the eyes and found old and recent hæmorrhages with retinitis suggestive of albuminuric retinitis.

Owing to emphysema the amount of space occupied by the heart could not be ascertained; but there were no adventitious sounds (with the exception of an accentuated second aortic sound). The arteries were thickened and the pulse was of high tension. These then are the important anti-mortem pathological symptoms—as far as could be ascertained albumin and casts in urine, albuminuric retinitis, thickened arteries and high tension pulse; but it must be remembered that the urine was inclined to be scanty, was loaded with urates, and had sp. gr. 1030.

Post-mortem.—It was discovered that the chief morbid change consisted of a largely hypertrophied left ventricle with no corresponding kidney changes. Now I wish you to consider the likely causes of this hypertrophy. I will briefly mention them under six headings:—

1. The kidneys were certainly not granular. Capsular of normal thickness and not adherent. Surface perfectly smooth. No cysts in cortex. *On section* they presented a deeply congested appearance. In consistance they were tough and indiarubber-like. Cortex was of normal size. The only abnormal change besides the congestion—as far as could be ascertained macroscopically—was a slight thickening of the smaller branches of the renal artery. The changes in the kidney then denoted a *result* of a cardiac condition, rather than a cause of it.

2. Aortic valves was healthy. There was no stenosis or regurgitation.

3. No dilatation of first part of aorta. No atheroma of the part sufficient to account for hypertrophy. This condition also excludes aneurysm of first part.

4. There was no primary disease of mitral valves leading to incompetence. Further, the amount of hypertrophy was—in Dr. Bryant's opinion—in excess of what is usually found in association with primary mitral valve lesions leading to regurgitation.

5. There was no pericarditis.

6. Right coronary artery was examined and found to be thickened and atheromatous, as also were many other arteries.

Therefore, the *primary* cause of the hypertrophy appears to have been an arterio-sclerosis associated with chronic alcoholism.

This case would point to the fact that it is impossible in some cases to diagnose cases of primary arterio-sclerosis from cases of chronic nephritis.

The following points are noteworthy.

Occasionally hypertrophy of left ventricle is found as primary in chronic alcoholism without any change in kidneys or arterial change. *Cause*, excessive strain on ventricle. Retinitis may occur on very slight kidney changes, or as a result of a short acute attack of nephritis leaving no microscopical changes, or as secondary to heart lesion.

In this case definite attacks of "asthma" were noticed, which were much relieved by Amyl. Nitrite and stramonium leaves.

His alcoholic habits were known, but his liver proved absolutely normal.

His feet were œdematous, but this improved, and apparently he was a case of arterio-sclerosis probably as the result of chronic alcoholism, while the kidney disease was very slight.

S. C. B.

Appointments.

CIVIL.

DISMORR, HENRY BERTRAM, L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer for the Wroughton District by the Swindon Board of Guardians.

DUFFETT, H. A., F.R.C.S. Eng., has been appointed Medical Officer to the School Homes of the Greenwich Union.

Passim.

The recent Preliminary Scientific (London University M.B.) list is particularly pleasant reading for all interested in the success of Guy's as one of the Schools of Medicine of the reconstituted University. An analysis of the places of education in the complete list gives the following result:—

Guy's	22
University College ...	10
St. Bartholomew's ...	8
St. Mary's	6
St. Thomas's	5
King's College ...	3
London Hospital ...	3
Westminster	3
St. George's	2

Thus Guy's has obtained more than twice as many successes as any of her competitors, and is responsible for more than one-third of the total number of successful candidates from the London Schools of Medicine, excluding the School of Medicine for Women. But a still more satisfactory feature of the list is the large proportion of Guy's students who have passed both parts of the examination at the same time. We believe that this is the best criterion of true teaching as opposed to cramming that can be elicited from a mere inspection of the pass list. In the entire examination Guy's has 9 places, University College 3, St. Bartholomew's and Westminster 1 each. Lastly, Guy's has 3 men in the first division, and University College 1. Well done, Guy's! Our heartiest congratulations to the lecturers and demonstrators in chemistry, physics and biology.

Equally cordial are our congratulations to the teachers of the intermediate subjects. Here is an analysis of the results at the recent Intermediate M.B. examination. Entire examination:—

Guy's	12
St. Bartholomew's ...	5
London	3
St. Thomas's	3
University College ...	3
St. George's	1

It is most satisfactory to see that no Guy's man passed "excluding physiology." We do not know if any Guy's man tried to, but if so, while condoling with him, we cannot help being gratified that he was ploughed as an example to other evil doers. There is no one more to be pitied than the London University man in the wards who is still wrestling with physiology. We note that one such candidate from Guy's completed his examination this time, and hope, for everybody's sake, he may be the last of the race of physiology excluders.

We are glad to see that Mr. Alfred Beit, one of our Governors, has returned to England after his recent severe illness in South Africa. His improvement in health is all the more gratifying when we note that he attributed it to the devotion and skill of Dr. Davies, late Imperial Light Horse, Dr. Rogers, late South African Light Horse, and Dr. E. T. E. Hamilton, whom some will remember here as House Surgeon and more still as Demonstrator of Anatomy, who also served in the R.A.M.C. during the war. The fact that their services were so distinguished during the war makes us all the more proud to claim them all as "old Guy's men."

The decree has gone forth at last after much discussion, and in future students desiring the appointment of "Extension Dresser" will be required to place the names of the surgeon in order of choice in the same way as at the first application made by them. The rule no longer holds good that an Extension Dresser must necessarily be appointed to the same surgeon to whom he has dressed in the first three months. This makes the appointment similar to the medical ward appointment, and is a distinct step towards greater diffusion of knowledge.

The palmy days of the dresser at the front are gone for ever, but the appointment is even more valuable than before. Six years ago the dresser in the four great firms was torn between conflicting theories and practices, all irreconcilable, but nowadays the question of sepsis has passed from the region of theory and fad to a

defined and simple position, and the practice of all our senior surgeons is now similar in all but detail, so that probably the surgeon could not detect the difference between his own dresser's methods and another's. The only difference is personal and traditional. The method of application of splints and plaster remains the only test of the firm, and the interchange of dressers will probably result in the best surviving, as the aseptic method of dressing has silently superseded all others in the hands of the dressers.

THE Physical Society's meetings have been much better attended. The paper on "The After Treatment of Abdominal Operations" was read to an unusually large audience, chiefly of the most senior men, and the Pathological evening was crowded, the fullest we remember, and the cases shown would bear comparison with any society in the world. It is, however, a pity that those men who take the trouble to bring the cases and get them up, do not write out a short abstract after the clinical report. It is only the gifted few who can improvise a crisp and accurate abstract while turning over several pages, and it makes the case more interesting to listen to and follow.

PSYCHOLOGY as all men know is "a blind man looking in a dark room for a black hat which isn't there." There may be, however, among our readers some to whom it is more intelligible, and to them we dedicate the following extracts which we recently came across in a learned disputation, and which embody some interesting or abstruse ideas.

Hysteria is "a disease of the hypnotic stratum."

"The hypnotic trance is a developed sleep."

"Sleep is a phase of personality in which subliminal operators are especially active."

"Hypnotic suggestion is an appeal to subliminal self."

Who can fail to recognise the "magnificent roll of words" that characterises this:—

"It is about that physical centre of imagined utterance that the emotional stress will gather, and the inexplicable promptings throng; through that motor channel the reverbating tremors rise and fall, and flood the flats of common consciousness as with the earthquake wave of an unfathomed sea." This is not the extravagance of Baboo English, but psychology.

IT may, then, be enlightening to learn the vocabulary, and surely to even Dr. Pye-Smith and Dr. Perry a guide other than the Classics would be necessary.

Pancæsthesia expresses the undifferentiated sensory capacity of the supposed primal germ.

Entencephalic—sensations which have their origin in the brain.

Cosmopathic—poetic word—open to messages from beyond the realm of sense.

Promnesia—the paradoxical sensation of recollecting a scene which is only now occurring for the first time; or the sense of the *déjà vu*.

After this, telæsthesia, telepathy, and motor automatism (a sharply modern ring this), are but easy figments, and a true understanding of the supra liminal and subliminal state seems to follow naturally, so naturally that one might almost fancy one was in a dream. Still, we feel more interested in life now that it is almost certain that each one of us has an astral body and a subliminal (a sublunary?) consciousness. And yet, seriously, it is a noble and a scientific study.

A MOST novel and revolutionary proposal has recently been under consideration by the authorities. It arises out of the difficulty experienced in getting certain cases into hospital, and the proposal is that the unused beds should be "pooled," and filled through the agency of a central telephonic office by the surplus at the various hospitals. Thus, when Guy's has not a female medical bed, we shall find that St. George's has, and forward the case we cannot take to them—after securing it through the telephone. It sounds simple and desirable; let us therefore examine the facts and try and see if the universal condemnation it has met with is merited. The present system is well-known. It may be briefly stated thus. All acute cases have beds found for them, all interesting but not acute cases have arrangements made for them. There remains over (neglecting of course mistakes in diagnosis of the above

conditions which are inevitable and common to any system) the chronic and usually incurable, the cases that others want to get in and that no small part of the population which wants to get in because they like being nursed and being invalids.

It follows from what has been said that no acute case or very interesting case will ever be sent on to another hospital. From this it follows that the other hospitals will look with great disfavour on any case that has already been refused admission. No strangulated hernia, no perforating appendix, no ruptured extra-uterine will ever, or ought ever, to leave the nearest hospital it reaches, and all hospitals are bound to leave a margin of beds to meet such cases. Therefore the cases that will benefit are those like hæmorrhoids and fistulæ, chronic Brights and chronic rheumatic fevers, and latent parametritis, and these do undoubtedly find the hospital usually full when they apply; that is, they are not suitable for acute beds, and there is no margin of spare beds. They cannot be admitted unless there are several beds, unless the Resident wishes to face a difficulty with his acute cases later on in the day. In fact, the reason these do not get in is that there is not a sufficiently large margin in the hospital, *e.g.*, consider the extreme rarity of an empty bed in Mary or Queen. We live from hand to mouth, and a vacant bed is almost always instantly filled, especially the female ones.

At present, if a case comes up that would suffer if not taken in, and will not, or cannot, go to the most excellent infirmaries, the Resident endeavours, usually with success if it is a proper case, to get it in elsewhere, usually at some friendly hospital, but it is actually very rare for this to be necessary. The point is, that at present no case that, from the medical school point of view, is interesting is lost, and that practically no seriously ill case is lost under the present system, and that, as we are always just one or two beds only short of being actually full, the arrangement will only benefit us by giving the disappointed but less afflicted applicants to us a bed elsewhere. We feel sure, unless the accommodation is greatly enlarged, that we shall practically never take any patients off anyone else. We think the present system a compromise, but an all but ideal system in working, because the system of "office" beds enables country cases and patronage cases to come in as required. The system of Residents ensures an absence of "pressure" and an impartiality that means a fair selection of cases. If it were the case that we were ever with empty beds and no patients, the scheme might increase our usefulness, but this is never the case. If it is the case that other hospitals have beds and no cases to fill them with, we feel we shall often be able to fill them; but all hospital authorities know how unsatisfactory another man's estimate of the urgency of a patient's condition is. We are inclined to think that the present system answers well. Practically the only cases we now lose are children and babies with acute diseases, for which we have extremely little accommodation.

Another point of view is that infirmaries are becoming the refuge of acute cases, because the nursing is good, the medical attendance usually excellent, and the admission certain. If some system of closer co-operation with infirmaries were arranged, the acute cases and cases that *ought* to be in Guy's, Bart.'s, and elsewhere, might be transferred to Guy's, and the cases that only require a home and a nurse, might be profitably exchanged for them, like the cases that are often transferred to us from fever hospitals and asylums. We think there is a great opening in this line to increase the usefulness of the big hospitals which are equipped for the treatment of such cases, and the infirmaries might return to its condition of being an infirmary, and not a hospital. We are informed that, *e.g.* the Clapham and Lewisham infirmaries are full of hospital cases, because of the uncertainty of getting in at the big Hospitals.

The Association XI. will meet St. Thomas' on Tuesday next at their ground at Chiswick, for the Final Tie, and the Rugby XV. and the London XV. on either Tuesday, March 6th, or Wednesday 11th.

Abstract of a Clinical Lecture on Severe Hæmorrhage from Ruptured Tubal (Isthmus) Gestation.

By J. H. TARGETT, F.R.C.S.

DURING the past eighteen months there have been four cases of this nature under treatment in Guy's Hospital. Three of them were for various reasons admitted into Clinical ward, while the fourth forms the subject of these notes. It has been calculated that such cases constitute only 10 or 12 per cent. of all forms of tubal gestation. Hence they are by no means frequent, but from the gravity of their symptoms and the difficulties in diagnosis, they are of great clinical interest and importance.

When gestation occurs in the thin narrow part of the Fallopian tube (known as the Isthmus), the changes produced differ from those which result from the common variety of tubal pregnancy. There is little or no hypertrophy of the wall of the tube; the muscular coat is rapidly eaten away by the proliferating epithelium of the chorionic villi until merely the serous membrane remains; and the gestation becomes disturbed at an unusually early period in its development. Moreover this disturbance almost invariably takes the form of rupture of the sac, followed by profuse and alarming hæmorrhage into the peritoneal cavity. The dramatic suddenness with which a woman in apparently good health is placed in imminent peril of her life naturally impresses the mind of the student. For that reason I particularly wish to use this rare case as a *contrast* to what may be called the ordinary results of tubal pregnancy, and, while pointing out its peculiarities, to emphasize the clinical features of such cases as we are likely to meet with at any time in the out-patient department.

I will now read the notes taken in Queen Ward. F., 41 years, married to second husband ten months—the last child by the first husband was six years old, She was admitted at midnight on Monday, November 3rd, 1902, and the following history was obtained:—About 6.30 p.m. the previous evening (Sunday) she was suddenly seized with severe pain in the lower part of the abdomen, and became so ill that she had to be helped upstairs to bed at once. She was sick and faint and the pain continued throughout the night. Her husband applied hot flannels to the abdomen, and as she was so much worse in the early morning he sent at once for a doctor. According to the friend's statement the case was regarded by the doctor as "the King's disease" (*i.e.* appendicitis), and medicine was sent to relieve the pain. Later on in the day she continued to get worse and her husband then determined to send her to a hospital. She was brought from Woolwich to Guy's in an ambulance and admitted to Queen ward at midnight, or some thirty hours after the onset of the attack.

On admission.—The patient was a big stout woman and extremely blanched. Pulse 140, very soft and compressible, temperature 98, respiration 28. She stated that she had been quite well up to the time when she was seized with the acute abdominal pain. The monthly period, however, was about a fortnight over time, though there had been no other symptoms of pregnancy. No morning sickness or secretion in breasts.

On examination.—The abdomen was large, partly from obesity and partly from flatulence, and was very tender on palpation. No tumour could be felt. There was no vaginal discharge, but after a bimanual examination there was a slight stain on the finger. No tumour could be detected in the pelvis, though the pouch of Douglas seemed full and rather baggy. She was sick once after admission and was in a restless condition, moaning with pain. The diagnosis of ruptured tubal gestation was made and immediate operation advised.

Operation.—When under anæsthesia, the abdominal wall was rapidly cleaned and prepared for laparotomy, and at the same time two assistants made preparations for infusing saline fluid into the left brachial vein. The peritoneum contained a very large quantity of fluid blood and clot, and bowels were very much distended with flatus. Hence, there was considerable difficulty in getting a view of the pelvic cavity. After clearing away much c ot, the left hand was passed into the pelvis, and the fundus of the uterus was grasped. Owing to the fat in the abdominal wall, and the early stage of the gestation, the uterus could not be brought up into the incision, but a slight irregularity was felt along the left tube. By strong retraction of the abdominal wall on that side and washing out the peritoneum with hot saline fluid, an imperfect view was obtained. About half an inch from the left corner of the uterus was a small ruptured gestation sac in the isthmus of the left tube. It was oval in shape and about three-quarters of an inch by half an inch. The ovum had escaped and was lost in the clot. The tube was held up with forceps, and a double ligature passed through the left broad ligament below the sac; one half of it was threaded through the uterine end of the tube and then tied, the other piece was passed between the fimbriated end of the tube and ovary and tied. A separate ligature was then applied round the pedicle thus formed, and the tube excised. The peritoneal cavity was again washed out with hot saline fluid, and the abdominal incision was quickly closed with deep sutures, much saline fluid being left in the abdomen. While this operation was in progress some three pints of salt solution had been injected into the brachial vein. She was taken back to bed, warmly wrapped up, and strychnine mv. injected. During the night small nutrient enemata were administered, and towards morning a small morphia injection was given to prevent restlessness. Twelve hours after the operation the pulse was 120, temperature 99°, respiration 28. She complained of much pain high up in the abdomen, which was attributed to flatus. A large saline enema was given, but not retained, and she was sick and restless. A few hours later the condition was not satisfactory, the pulse was feeble and still very rapid—130 per minute. The epigastric pain continued. At 6 p.m., or about

fifteen hours after the completion of the operation, she suddenly became very collapsed, lips blue, pulse imperceptible, and died in a few minutes.

The post-mortem examination showed that the pedicle was securely tied and that there had been no fresh hæmorrhage into the peritoneum. here was, however, extensive thrombosis of the splenic vein and its tributaries from the stomach. The spleen was considerably enlarged and its substance mottled with areas of congestion and extravasation, due to clotting of its veins. The thyroid and thymus glands were both enlarged, but not the lymphatic glands. On microscopical examination of the spleen, it was found that the stroma of the organ was more fibrous than normal and in considerable excess. But there was nothing to explain the thrombosis of the chief veins.

Remarks.—Let us turn our attention firstly to the symptoms of this case and consider them in the order of their development:—

(*a*) *Sudden onset.*—The previous history of the patient is normal so far as this illness is concerned. She was singing hymns with her children on Sunday evening when the attack commenced, apparently in the best of health, and free from any pain, abdominal or pelvic.

(*b*) *Severe abdominal pain.*—A patient may describe a feeling of "something having given way" in the lower part of the abdomen, and this is quickly followed by a severe pain, which is almost paralysing in its intensity. The patient sinks down where she happens to be, or has to be helped to bed.

(*c*) *Vomiting* or other signs of peritoneal irritation may occur. This is important to remember, as the case may thus simulate a strangulated hernia. The sickness, however, is at the beginning of the attack, and does not increase in severity, as in intestinal obstruction.

(*d*) *Signs of internal hæmorrhage.*—It is remarkable what a very large quantity of blood may be poured into the peritoneal cavity from the rupture of an isthmus gestation-sac not larger than an hazel nut. Sometimes the patient becomes rapidly collapsed and dies before any operation can be carried out. But more frequently the hæmorrhage causes fainting, and the bleeding is thus lessened or temporarily ceases. After a time the usual signs of internal hæmorrhage are present, rapid soft pulse, subnormal temperature, shallow quick breathing, blanching of the lips and face, restlessness, and increasing anxiety of countenance. She lies on her side with the knees drawn up, and the abdomen is often excessively tender, suggesting peritonitis.

(*e*) *Amenorrhœa.*—I have placed this symptom last because it may be absent owing to the very early stage of the gestation at which the rupture occurs.

Thus, in one of the Miriam cases last year the rupture occurred on the seventeenth day after the patient (an unmarried girl) had "gone wrong" for the first and only time. In another instance that I know of, the sac ruptured on the twelfth day after a single coitus, and the hæmorrhage was fatal. Further, the patient may be suckling at the time, and therefore the menstruation is absent. As a rule, however, the patient has missed one period and is one or two weeks over her time.

Physical examination reveals very little. The abdomen is often too tender for much palpation, but it is likely to be somewhat distended in the lower zones, and there may be dulness in the loins, with the signs of free fluid. The condition of the patient usually precludes such examinations. Per vaginam, the pouch of Douglas may feel boggy or distended with fluid, but there is no definite pelvic tumour to be made out and no displacement of the uterus. Finally, there are no mammary signs of pregnancy.

Before enumerating the common signs of tubal pregnancy, let me remind you that the gestation usually occurs in the outer or ampullary portion of the tube, that it generally attains to a more advanced period of development before it becomes disturbed, and that this disturbance in the great majority of cases is due to the formation of a tubal mole. Such a case is by no means infrequent in the Out-patient department. The patient comes up on account of pain and continuous losing, and perhaps thinks she has had a miscarriage. There is a history of missing one or two periods before the discharge from the vagina begins. The characters of this vaginal discharge I have often pointed out to you. It is of a brownish red colour due to the breaking up of the blood in it. The quantity is not large and there are no clots as in a threatened abortion. But the discharge is almost continuous and does not come in gushes or intermittently as in abortion. The account which the patient gives of her illness is very variable, and this is not surprising when we consider the differences in tubal moles and their hæmatoceles, both in size and situation. Some cases describe a sudden onset of abdominal pain with collapse, but not followed by the signs of progressive internal hæmorrhage. In other instances the symptoms are milder, cramping pains in the lower part of the abdomen, bearing down, and pelvic discomfort generally. For diagnostic purposes we rely chiefly on the amenorrhœa, the vaginal discharge, and the presence of a pelvic tumour. This tumour is situated behind the uterus and more to one or other side of the pelvis. Consequently the enlarged uterus is pushed forward and in the opposite direction. The tumour is fixed, rounded or uneven in outline, and semi-elastic in consistency. When such a case is seen at the Out-patients there are three conditions which must be excluded in making a diagnosis:—

(*a*) Threatened uterine abortion.
(*b*) Retroverted gravid uterus.
(*c*) Pelvic tumour and uterine gestation.

We cannot further discuss the differential diagnosis now, but mention must be made of the decidual cast. I did not include it among the symptoms of ordinary tubal (molar) gastation, because we so rarely see it, and no reliance can be placed on the patient's statement of having passed a "piece of flesh." It is usually given at examinations as the most characteristic sign of tubal

gestation, but in practice it is of little value and we can make an accurate diagnosis without it.

I must now return to our original case and say a few words about treatment. When the diagnosis of severe internal hæmorrhage from the rupture of an early tubal pregnancy has been made, an abdominal section is urgently required. From some points of view the operation is easy, and can be carried out with a very small supply of instruments if the urgency of the case prevents the patient from being removed to more favourable surroundings. There are no adhesions, the gestation sac is small, and the tube can be tied and removed without its ovary. The difficulties are these:—(1) The field of operation is flooded with blood and clots which obscure the view; (2) the bowels are generally distended with flatus because the patient has not been prepared for operation in the usual way; (3) the sac is very small and not easily felt; (4) it is sometimes so close to the uterine cornu that there is scarcely room to tie a ligature securely between it and the uterus—if the uterus is wounded, the hæmorrhage is difficult to control. Do not waste time in washing out all the blood and clots from the peritoneum. They cannot be wholly removed by irrigation, and will absorb in time. While the abdominal incision is being closed rapidly, let some warm saline fluid flow into the peritoneum, and at the same time a saline infusion may be given into the brachial vein or the cellular tissues. Get the patient back to bed as quickly as possible and wrap her in hot blankets, etc., and keep her perfectly quiet, if need be, with a small injection of morphia. Small feeds by the mouth can be begun early as there is generally not much sickness.

Inter-Hospital Rugby Cup Tie.

SEMI-FINAL.

GUY'S v. ST. THOMAS'S.

This match was played at Richmond yesterday (Friday). As we go to press we receive the news of a victory for our hospital, the score being as follows:—

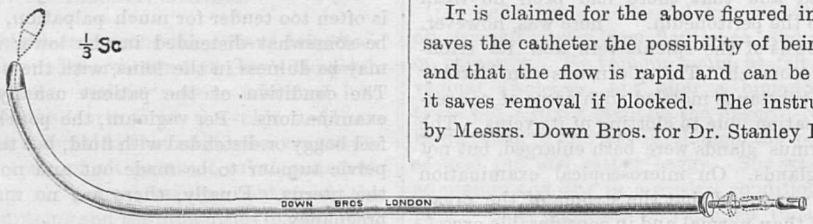
GUY'S	...	6 points.
ST. THOMAS'S	...	Nil.

We hope to publish an account of the match in our next issue.

Novelties.

A NEW SILVER CATHETER.

IT is claimed for the above figured instrument that it saves the catheter the possibility of being often blocked and that the flow is rapid and can be regulated; that it saves removal if blocked. The instrument was made by Messrs. Down Bros. for Dr. Stanley Raw.



Types of Doctors.

No. 1.—SUCH A NICE MAN.

When all was said about our doctor, his virtues seemed to be summed up when the verdict was given that he was such a nice man. I may say at once that this was the judgment of the ladies. The men always regarded him as fussy, and more than once spoke of him as a conceited ass, which, however, was rather unkind. In our particular section of Suburbia the ladies made a doctor's fortune. They do so in most places, but with us they were all-important in matters medical. In our locality, every quarter-day brought a fresh flock of immigrants, or rather birds of passage, for they only stopped a short while, and went away again. They were restless creatures. If the new arrivals lived in a large enough house and kept more than one servant, they were admitted into society on approbation, the first step being the usual courtesy calls. Of course, if they were too impossible, or the bread-winner referred too much to his vulgar occupation of making money in the City, they were liable to eviction. Men are often vulgar and talk of their work. This cannot be countenanced, for in very polite society is it not always taboo?

Any new lady, once admitted to our coterie, became the bosom friend of any other in a few days, and they shared their family histories in an impartial manner. These friendships, it must be owned, were not lasting, and were liable to be completely wrecked by some small submerged rock in our great sea of etiquette. That must always remain so, or how could our social status remain unimpeached by other less-favoured mortals?

Naturally one of the first services required of a friend was the name of a nice kind doctor, and it was from this fact that our doctor always attached all the new members of society to his chariot wheels, for he was certain to be recommended.

He was really a nice man if one knew him, and he had more virtues than our society dreamed of. His sole claim to niceness did not rest on his professional manner, which was simply a work of art. His wife was only tolerated, but the doctor made no concealment of his affection for her, which she thoroughly deserved.

The ladies, however, had decided that his marriage was unfortunate, and that his wife was not good enough for him. To my mind this line of thought simply reflected their great affection for the doctor, clothed, however, in invidious terms. There was no doubt that they did like him, for he was one of the men that they found to possess the heaven-sent gift of sympathy. This is always considered an attribute peculiar to the female sex, and special dispensations had to be granted before the doctor had undisputed possession. This once established, he was an absolute necessity on the occasion of any slight ailment, for he could say such nice kind things, which to a non-critical mind bore the stamp of truth. When I look back on his triumphal progress, I see that the starting point was this wonderful gift of sympathy, and although it sounds rather common place, I am sure he earned it by saying that the ladies were so fragile and delicate, and suffered from their nerves. He felt himself a hypocrite in doing so, but on the first occasion of use it met with such marked success that he was always forced into it afterwards. It was against his will, I know, but he had himself in good control at most times. Once I called on him and found him suffering with indigestion, and very despondent. He bemoaned his fate, and resolved to shake off his fetters. "Courage, old friend," I said. "These little things are only sent to try us." When he recovered he saw things in a better light, and resolved not to hurt any body's feelings.

Confidentially I may mention one of his happiest doings, quite an inspiration. He kept a birthday book, and on any really good patient's birthday he called and "ran in" "Very busy," he would say, "but I remembered it was your birthday and just ran in to wish you, etc.", and would produce a pretty little bouquet as an offering. It was certainly money well laid out, as I heard a crusty old gentleman say, but the ladies only saw the poetry of it, and did not look at it in a sordid way.

When he spoke of "running in" he was absolutely correct, for directly the carriage stopped he simply dashed for the house. When he was middle aged it made him so out of breath, and was of no practical use, for his reputation was made, but in his youth people thought he had not a minute to spare, so busy must he be. It was this keen study of detail that caused him to rise high above the common place. In the summer it was an education to watch him get into his victoria, throw himself back, and then cross his legs with the most careless grace in the world. I often longed to applaud, as one does at the small perfections of acting which make the stock in trade of trade of a polished actor.

There will I leave him, he is still there, living in affluence, working hard, conscious of his ignorance, of his undeserved success over better men, acting all the while in a part which he does not care for, and who shall say that he is not one of the "martyrs of civilisation?"

Guy's Hospital Dental Society's Dinner.

Prospero:

For this, be sure, to-night thou shalt have cramps,
Side stitches that shall pen thy breath up; urchins
Shall forth at vast of night, that they may work.
All exercise on thee; thou shalt be pinched
As thick as honeycomb, each pinch more stinging
Than bees that made 'em.

Caliban:

I must eat my dinner. —*Tempest.*

There is a certain law, unwritten, and for that same reason most potent, which declares that the consummation of each year of any society's "glorious life" shall be a public and deliberate ingestion of large quantities of food, followed by a plethoric pause, during which those cursed in any way with "the gift of tongues" shall exhibit their powers, to their own deep grief, and for the delectation of the company.

In accordance with this same law, the Dental Society, its numbers swelled by illustrious guests and a few strolling players, held its Annual Dinner at the Trocadero Restaurant on the evening of Saturday, February 21st. Now the Dental Society is justly noted for the magnificence of its banquets, and the eyes of Mr. Parlow's dog never glistened as did our own as we pressed eagerly from the reception room to the scene of combat. In our case, however, there was something better in store than "psychic feeding," and we were not disappointed. Time would fail us were we to speak of potage and poisson, entrée and entremêt, and the sense of delicacy of the intellectual reader would be offended at the fleshly details. Let us rather pass to the intellectual gymnastics of the after-dinner speakers, and to those artistic interludes during which their oratorical flights were planned, avoiding all reference to mere gallic gastronomics.

The toasts of the King and the Royal Family having been solemly drunk, and Mr. W. H. Yeo at the piano having given an admirable rendering of "Down South," it fell to the lot of Dr. Taylor to propose the health of Guy's Hospital and Schools.

Dr. Taylor declared that this particular toast, almost equalled in its solemnity, the two toasts which had preceded it. He would avoid the great temptation to an historic retrospect, and would refrain from making the time-honoured remarks almost inevitable in such a speech as the one he was called upon to make. He hoped that present Guy's men would be "as good as their fathers," and trusted that as a community their shadow would never grow less. He doubted whether the present generation excelled those of the past, in as great a degree as it ought to do, but there were honours recently gained, the like of which our fathers could not boast. He referred to to the recent appointment list of the Royal Army Medical Corps, in which Guy's names figured so largely. The shadow

of Guy's Hospital was certainly growing in the material sense, the new Nursing Home being an imposing addition to its mass; and he hoped that as the Physiological building climbed to the skies, the old Museum buildings would some day cease to be. In a far wider sense the hospital was growing and was extending its branches from England to the Antipodes. Thus far he had spoken of the hospital as a whole. But he desired to speak of the Dental School in particular with the greatest cordiality and admiration. Its rapid growth since its foundation in 1889 up to the present day, was a standing tribute to the energy and wholeheartedness of its leading spirits. He called on the company to drink the health of Guy's Hospital Schools, coupled with the name of the Dean, Dr. John Fawcett, whose estimable qualities were too well-known by all present to require any comment.

Dr. FAWCETT in responding, spoke of the difficulty he felt in so doing. The task of proposing such a toast would have been so much more congenial; also he had done this sort of thing so often before, that the constant repetition was telling on him. He often wondered what those great men who founded the schools would say if they could see them in their present advanced state. In the old days, "walking the hospital" was literally the whole duty of the student, and the first advertisement for intending students appeared in 1772, to the effect that "Clinical Lectures would be delivered at Guy's Hospital on cases of patients, by means of which students could enjoy every advantage, etc., etc." He felt on reading this that it should have been followed by the time-honoured intimation that applications should be made to the Dean, or to his accomplice (he begged pardon, his clerk) S. H. Croucher, Esq. For the connecting links between these two advertisements he referred us to the History of Guy's Hospital by Wilkes and Bettany. There was *Dr. Addison* who initiated the practice of case-taking, and *Gull* who was the first registrar. In those days, too, Botanical Lectures were a *sine quâ non*, and "Old Johnson," the lecturer, would begin his lectures with "Gentlemen, a short time ago an unfortunate ship's crew were wrecked on the shore of a desert island. Their stores had run out and starvation stared them in the face. But a certain Guy's surgeon among their number, grubbing up a root said 'Gentlemen, you may eat that bulb with impunity.'" Signing-up was in its infancy, one course of anatomy and one of surgery being all that was required. Then, too, those were Deanless days—the Dean, in fact, was a morbid outgrowth resulting from the malign influences of examining boards. The Dental School was the last great hostage to fortune—it was the youngest member, still in fact in its teens, but it was fulfilling the promise of its early youth. The coupling together in the toast of the two Schools was a sign of the strong bond of fellowship existing between them, and it was on this union that the fullest success of both depended. Dental students were playing their part nobly in winning laurels for the Hospital—he would like to specially mention Mr. Lennox-Jones (Inter M.B.), Mr. Piper (Arthur Durham), Mr. Spiller (last year's Hilton prize). He had received letters from Mr. Alfred Fripp, Mr. Cosmo Bonsor and Mr. Lumley (one of the late secs.) expressing regret at their inability to be present. He thanked the company for the very kind way in which they had drunk the toast.

The next item on the programme was a recitation by Mr. Ray Edridge, who gave us a harrowing description of the horrors attendant on the use of the telephone—Jerome K. Jerome was his authority on the subject. Being encored he gave Kipling's "Terrible Story."

Mr. GOLDING-BIRD, in proposing the toast of "The Dental Society," said that it was a great source of satisfaction to him that he was unfettered by the privileges enjoyed by members of their society, and that as a simple member of the Clubs' Union he felt justified in playing the part of the unbiased critic. The inception of a society was always an interesting process. Four or five ardent spirits gathered together, fired with a common enthusiasm, and the order of procedure was as follows:—

1st. They dined.
2nd. They constituted themselves a "club."
3rd. They gave that club a name.
4th. They made it a rule that it should be the privilege of each member to invite guests.

Man was a gregarious animal, and in his amiable habit of thus enrolling himself and his fellows under a common banner he was merely following a primæval instinct. The Guy's Hospital Dental Society was one of the happiest results of this self-same process. The history of the growth of the art and science of dentistry was an interesting study. He supposed that of late years the casual observer would have been struck by the rapid strides towards the perfection of mechanical dentistry made on the part of the Americans. But he ventured to assert that higher work had been done in England in the purely pathological realm. In this history of dentistry Guy's Hospital played a large and honourable part, and he mentioned the names of Joseph Fox, Thomas Bell and James Salter, three "giants of the past," who had played no small part in the history of their profession. The striking developments of late years somewhat obscured the essential antiquity of dental science. Were not dentures found on Egyptian mummies? He would especially incite the members of the Dental Society to essay flights into the realms of original research. Youth was too often put forward as an excuse for abstention from this solitary exercise. But the members of the Physical Society were not so humble; he especially mentioned Larkin who, in 1859 wrote a paper on Nephrectomy, which he had made for some years his study; also Mahomed who, in 1870, invented a form of sphygmograph. One of the chief points about societies such as the Dental was the opportunities it affords for public debate, with that interaction of ideas which is especially stimulating to the young student. The man who worked always and only by himself was no better than an entomologist or a stamp-collector. The fact that the chairman of the Dental Society was always a member of the Staff, and

that he always officiated in person, was a great point, and the Clinical Evening was "a grand thing." He proposed the health of the Dental Society, coupled with the name of Mr. Maggs, one in whose hands the high dignity of the profession would ever rest secure, and whom many of the younger men present would have the felicity of encountering over a green cloth table in the "hall by the sea."

MR. MAGGS after expressing his thanks for the kind way in which the toast had been proposed and received, fully endorsed the previous speaker's remarks as to the gregarious propensities of the human animal. He also advocated constant attendance at the meetings of the Dental Society, because of the many educational advantages afforded by so doing. He stated that as opposed to the 35,000 men enrolled on the Medical Register, there were only 5,000 on the Dental; there was thus room for many more men; foreigners were distinctly unwelcome; what was wanted was an influx of well-educated men who would uphold the honour of the profession. He regretted the absence of Mr. Newland Pedley, and briefly alluded to the origin and growth of the Society, with which the latter had always been so intimately connected. He was glad to see so many men present, especially as "divers of them came from afar," and he hoped this interest in the society would not diminish in future years.

Messrs. Felton, Tracy, and Forty, next delighted the company with Balfe's "Wine the Magician," the same gentlemen, reinforced by Mr. Angell, subsequently sung Mendelssohn's "Vintagers' Chorus." Both pieces were altogether excellent, and these gentlemen are deserving of the highest praise for the way in which they must have sacrificed much of their valuable time in the rehearsing of the same.

The toast of "The Visitors," was next proposed by Mr. LEWIN PAYNE.

Mr. PATERSON in replying, declared that retrospect was the order of the evening. He had listened with great interest to Dr. Taylor and Mr. Golding-Bird, and he himself would now enlighten them on certain abortive transactions of history which took place before Guy's Hospital Dental School was born or thought of. Some years ago Mr. Newland Pedley presented himself at St. Bartholomew's Hospital, and confronting Mr. Paterson and three of his colleagues said, "You are four denta surgeons, why don't you start a dental school?' Bartholomew's was, even in those days, in great want of funds, and Mr. Newland Pedley retired discomfited for a time, to peg out his plans ultimately south of the river, and to get them carried out, with the result that is now seen. He wondered at first why he had been selected to reply to the toast in question. Mr. Payne, however, had enlighted him—he was an examiner!

Mr. H. T. Campkin next gave us a musical sketch entitled "The Silver Wedding," which was much appreciated.

The task of proposing the health of the Chairman, Mr. Campkin, fell to the lot of Mr. WYNN ROUW, who performed this duty in an exceedingly witty speech. He pointed out that Mr. Campkin suffered from that modesty by which all Guy's men were positively obsessed. One could always spot the one Guy's man in a room, because he always "hid his light under a bushel." If Mr. Campkin were a lady he would sum up his excellences in the term "personal charm." But Mr. Campkin, not being a lady, such a course of action was obviously impossible. Whatever the Chairman had put his hand to had prospered, and he offered him his heartiest congratulations on a highly successful season.

Mr. CAMPKIN thanked the previous speaker for the kind way in which he had proposed his health. He spoke of one of the results of the late war being the appointment of Dental Officer to the R.A.M.C. If the War Office saw the necessity in time of war, he hoped they would also see it in the "piping times of peace." He specially mentioned the appointment of Mr. Badcock to the corps in question. He then proceeded to propose the health of the energetic secretary of the Denta Society, Mr. Crofts. His efforts during the season, now drawing to a close, had been increasing, and they had been crowned that evening with that success which Fortune justly metes out to so ardent a votary.

Mr. CROFTS briefly replied to the toast of his health and the formal part of the evening was ended.

The Dental Society is to be congratulated on a dinner which was an unqualified success from start to finish.

Reviews.

The price of books submitted for review should in every case be stated.

The Brooklyn Medical Journal. There is practically no comparison possible between the English *Lancet* and the *Medical Journal.* One begins the latter with a sense of deep interest which deepens to amazement; afterwards is succeeded by philosophic doubt, and finally ends in despair and uncertainty as to what is true, what is exaggeration, or what advertisement. Without wishing to be unduly critical, one is astonished at the enormous number of extraordinary cases treated by extraordinary remedies, and by the wonderful recoveries. It is no longer in Africa, but in America. "Semper aliquid novi."

Memoirs and Letters of Sir James Paget. By his son Stephen Paget. (Longmans, Green & Co., 1903). 6s. net

This book enjoys a wide and deserved popularity owing to its interest both to its literary form, and to the personal elements involved. The book-reading public has read it keenly, and pondered over its revelations. It has in some sort seemed to lift the veil and to convey a peep behind the scenes of the career of the great surgeon.

We recommend all to read it. It has a deep human interest, it is the record of a honest giant, of labour long and of labour eventually rewarded. We will not attempt to spoil its perusal by quotation. It is well worthy of careful diligent reading.

Answers to Correspondents.

ARTICHOKES AND DIABETES.

I have examined the tubers of the Artichoke sent, and must confirm the generally accepted opinion that they must be *banned* as a food for diabetics.

Artichokes contain the carbohydrate inulin—a kind of starch which is soluble in water, and which, therefore, he did not see when he examined the section under the microscope.

I am at a loss to know why your correspondent did not get a reduction of Fehling's solution, with the watery solution in which the artichokes had been boiled. In my hands the reduction takes place very easily, moreover, if the artichokes be simply mashed up in cold water, the solution filtered and boiled with Fehling, reduction takes place, as one would expect knowing that inulin is easily hydrolysed to levulose.

To get a good microscopic section showing the inulin in crystals in the cells, it is necessary to soak the artichoke in spirit for some time.

ANALYST.

Pass List.

University of London, January, 1903.

INTERMEDIATE MEDICINE EXAMINATION.

ENTIRE EXAMINATION.—E. H. Adams, T. H. Barton, R. J. Bentley, G. Hamilton, E. M. Harrison, H. S. Knight, E. F. Milton, T. C. Pocock, W. P. Purdom, F. A. Sharpe, H. A. Watney, F. T. H. Wood.

PHYSIOLOGY ONLY.—I. R. Cook.

PRELIMINARY SCIENTIFIC (M.B.) EXAMINATION.

ENTIRE EXAMINATION.

DIVISION I.—S. H. Cummings-Air, L. Mandel, M. D. Price.

DIVISION II.—H. R. Bastard, R. C. V. Edsall, A. L. Gardner, J. B. Martin, H. E. Perkins, S. G. Tracy.

CHEMISTRY AND PHYSICS.—M. E. Ball, *A. F. Denning, J. B. Dunning, *T. Evans, *H. J. Henderson, K. H. Hole, B. McDermott, *M. J. Rattray, *G. F. Syms.

BIOLOGY.—S. S. Brook, G. B. Harland, *D. Reynolds, *H. J. Smith.

*Have now completed the examination.

Institute of Chemistry of Great Britain, January, 1903.

EXAMINATION FOR THE ASSOCIATESHIP.—H. Finnemore.

Appointments.

NAVAL AND MILITARY.

Staff-Surgeon E. R. D. FASKEN, R.N., has been appointed to the *Europa* for medical charge on the passage out, and to the *Ocean* on recommissioning.

Surgeon NORMAN L. RICHARDS, R.N., is promoted to be Staff-Surgeon and appointed to the *President* for Survey of Stores at the Royal Victualling Yard at Deptford.

Surgeon R. F. CLARK to the *Europa*, and to the *Rosario* on commissioning.

Lieutenant-Colonel P. A. WEIR, I.M.S., Bengal Establishment, is made Agency-Surgeon 1st Class, and is confirmed in the appointment of Administrative Medical Officer in Central India, from October 30th, 1902.

Major D. ELCUM, late Indian Medical Service, to be Lieutenant-Colonel, Army Medical Service.

Notice.

There will be a Smoker at 8 p.m. on Saturday, March 7th, Dr. PETER HORROCKS will preside.

Births.

FRITH.—On February 15th, at the Limes, Rickmansworth, the wife of Walter S. Frith, M.B., B.C. Cantab., of a son.

HICKS.—On February 12th, at Huntingdon, the wife o Charles E. Hicks, M.R.C.S., L.R.C.P. Lond., of a son.

STEAD.—On February 9th, at Moor Lodge, Hawkhurst, the wife of C. Clement Stead, M.B., etc., of a son.

STEVENS.—On February 14th, at 8, St. Thomas's Street, London Bridge, the wife of Thomas G. Stevens, M.D., F.R.C.S., M.R.C.P., of a son.

ED.—J. M. B.

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Calendar of Coming Events.

Mar., 1903.

Sat. 14.—Messrs. Golding-Bird and Dunn's take-in; Drs., G. A. Ticehurst and M. J. Mottram; Cl., H. S. Brown.

1 p.m., Clinical lecture by Dr. Taylor.

G.H.R.F.C., II., Borough Road College, away.

G.H.A.F.C., II., Central Technical College, away.

Mon. 16.—1.15 p.m., Clinical lecture by Mr. Steward.

Wed. 18.—1.30 p.m., Clinical lecture by Mr. Symonds.

Examinations for Junior and Senior Prizes for General Proficiency, for the Michael Harris Prize, and for the Wooldridge Memorial Prize begins.

Thur. 19.—Messrs. Jacobson and Fripp's take-in; Drs., R. D. Bridger and E. C. Myott; Cl., T. Morland-Smith.

Examination for Golding-Bird Gold Medal and Scholarship begins.

Fri. 20.—Meeting of the Dental Society at 4.15 p.m.

Sat. 21.—1 p.m., Clinical lecture by Dr. Taylor.

G.H.R.F.C., II., Hammersmith, away.

IV., Court Hill "A" away.

G.H.A.F.C., I., West Norwood, away.

II., Carshalton Park, away.

Debating Society, at 8 p.m. (Ladies Night).

Tues. 24.—Application to Medical School Office for Schedules for Final Conjoint Examination to be made not later than this date.

Dental Metallurgy Examination for 1st Year's Prize.

Dental Anatomy Examination for 1st and 2nd Year's Prize.

Wed. 25.—1.30 p.m., Clinical lecture by Mr. Symonds.

Dental Physiology Examination for 1st and 2nd Year's Prize.

Dental Anatomy Examination for 1st and 2nd Year's Prize.

Thur. 26.—Messrs. Symonds and Stewart's take-in; Drs., J. D. Thomas and R. Franklin; Cl., C. R. Howard.

Dental Surgery Examination for 2nd Year's Prize.

Lectures cease.

Guy's Hospital Gazette,

MARCH 14, 1903.

The Differential Diagnosis of Cases of Prolonged Pyrexia.

TWO CLINICAL LECTURES BY DR. F. TAYLOR.

LECTURE I.—February 21st, 1903.

GENTLEMEN,—The cases which I have to bring before you to-day are two instances of *malignant endocarditis*, which are now in the Clinical wards. The first case is that of a woman, æt. 23. In her previous history we find that she had rheumatic fever eleven years ago, a second attack of rheumatism six years ago, and a third attack three and a half years ago; in the second attack a pericardial rub and a mitral systolic bruit were observed, and in the third attack a soft mitral systolic bruit was heard.

She was admitted to the Eye wards in November, 1902, for dimness of vision, which was found to be due to optic neuritis, and during the period of her stay in this ward she had continuously a pyrexial temperature. About three weeks after her admission, that is in the middle of December, she was attacked with paralysis on the left side, so that she lost movement in the fingers, and was unable to lift or move the left arm. The mouth dropped a little on the left side, the tongue was pushed slightly towards the left side, and the left side of the face was smoother than the right. There was also less power in the left leg than in the right, but she could move them both.

On December 22nd she was transferred to Clinical ward, and her condition remains nearly the same, after nine weeks' stay, as it was on her first admission. She is in bed, with a constantly febrile temperature, of which we have a chart now from her first admission to the Eye wards,

extending over thirteen weeks; the left arm is slightly paralysed, there is a systolic murmur at the apex of the heart, and the optic neuritis is still present. The blood has been examined for streptococci, but none have been found.

The second case is that of a girl æt. 10, who was admitted into Clinical ward on January 3rd. She is described as having been a perfectly healthy child until three months before her admission, when she complained of pain in the left side and in the knees. She was treated as an out-patient for rheumatism, and appeared to be well in five weeks. About three weeks ago she began to complain of shortness of breath, and suffered from cough at night; but she had no treatment until the evening of admission, when she seemed worse and was brought up to the hospital. She was then found to present a systolic murmur at the apex of the heart, and also a very short blowing murmur just preceding the systolic murmur, but not "rumbling" or increasing in loudness up to the first sound. The spleen was palpable in the left hypochondriac region, but it was not tender. The liver was also enlarged, so that its edge reached nearly to the umbilicus, but it was quite soft. In her case also the temperature has been continuously febrile until the present time. On January 23rd a few petechial hæmorrhages were noticed on the body and limbs, and there were some fresh ones on the following day. The bacteriological report on blood supplied on the 22nd was practically negative. A few staphylococci of the white variety were obtained on cultivation, but they were regarded as accidental contamination.

These two cases may be accepted as cases of malignant endocarditis. The evidence of that complaint clearly lies in the existence of a cardiac murmur or murmurs manifestly due to endocarditis; in the long continuance of the pyrexial process over several weeks, which cannot, so far, be explained in any other way; and in the occurrence of other events or lesions which are either due to the associated toxic condition, or are obviously dependent upon impaction of particles carried from the valves of the heart into remote parts, and commonly known as emboli.

Amongst these, in the first patient, we have the condition of optic neuritis, and the hemiplegia, which is undoubtedly due to embolism of the right middle cerebral artery. In the second case we have the petechial hæmorrhages and the enlargement of the spleen.

I will here take the opportunity of calling especial attention to one result of this embolic obstruction which may easily be overlooked unless its possible occurrence is borne in mind, and that is the weakening or abolition of the pulse in one or more of those large and middle-sized arteries of the body which are accessible to direct observation.

It is interesting to note that the fact of a blood-vessel, such as the radial artery, or the posterior tibial artery, being obstructed in the course of malignant endocarditis by emboli carried from the valves of the heart, may not be apparent to the patient by any subjective symptom whatever; there is not necessarily any coldness of the limb or loss of sensation, much less any gangrenous or sloughing process, but the fact of obstruction of the vessel must be sought for by the physician himself, by direct examination of such arteries as can be felt by the fingers—for instance, the radial, the ulnar, the brachial, the posterior tibial, the dorsalis pedis, the popliteal, the femoral, and some others. It is not infrequently found in these cases that the absence of the pulse can be, in one or other of these places, demonstrated. For instance, in a case recently under my care in Mary ward, that of a woman of middle age, who came in with an extremely rapid heart, a short systolic apex murmur, considerable prostration, and at that time rather irregular fever, the left radial pulse was scarcely to be felt at all, and this condition persisted until her death after three or four weeks. She was found to have the malignant endocarditis, which we had diagnosed. In the present two cases the pulses have been examined, and they are all found to be in a normal condition.

Now, with regard to the temperature of these cases, that is to say, the pyrexia, which is to be the subject of our lecture to-day, I show you the charts, which will illustrate to you the variations that may take place in the course of

this symptom. It has been frequently stated that the characteristic temperature of malignant endocarditis is one of complete irregularity. For my own part, I rather object to the statement that a negative condition can safely be regarded as characteristic of anything; and this I am quite sure of, that in many of these case of malignant endocarditis the temperature may be absolutely regular over a period of several months. But then I mean by "regular," a regular oscillation from a low temperature in the morning to a high temperature in the evening, from 99° or 100° in the morning to 102° or 103° in the evening, such regular recurrence of evening pyrexia and relatively low temperature in the morning persisting day by day for the periods mentioned. In that sense I think you cannot say that the temperature is necessarily irregular. However, in the two cases before us the temperature has not followed quite this uniform course, but has sometimes been somewhat high, and at others somewhat low, although always above the normal.

After all that I have said you may perhaps feel that the differential diagnosis in a case of this kind is relatively easy; certainly these cases do not illustrate any of the difficulties. They will, I think, come out as we deal with pyrexia from other causes. I will, however, at once say that the fallacies occur in two ways—

First, in a case of malignant endocarditis, that apart from the fever and perhaps an enlarged spleen, there may be for a long time no evidences of embolism in any region of the body, and even *no cardiac murmur* to indicate the source of the sepsis.

Secondly, that in a patient with a definite endocarditis and cardiac murmur, other infective conditions may be contracted, such as typhoid fever or tuberculosis, difficult enough in themselves of early recognition; and hence confusion may easily occur.

Thirdly, I ought to say that some cases of malignant endocarditis are of very short duration in their pyrexial stage, when their diagnosis may also be difficult, but on somewhat different grounds. And now, at any rate, I am only dealing with cases of prolonged pyrexia.

Fourthly, assistance is occasionally afforded in malignant endocarditis by the occurrence of rigors, or chills, or sweats, which, however, are very variable indeed. Actual rigors, the most distinctive of this group, may occur daily, or singly at intervals of several weeks or months, or they may occur frequently for a time, and then disappear completely.

A good illustration of this subject under the first and fourth heads was afforded by the case of a patient who was under my care in Mary ward some four years ago, who was sent in for appendicitis in order to be operated upon on account of pain in the right iliac fossa. She had a high temperature, she had rigors even, for a week after her admission. The rigors then subsided but the fever continued for three more weeks; she had indications of broncho-pneumonia at the bases of the lungs, and she died. *Post-mortem*, malignant endocarditis was found, but during her life no murmur had been heard, although frequently listened for.

Typhoid fever.—Now, the next disease that I wish to mention is that very familiar complaint, typhoid fever, a disease which, in spite of the frequency with which we see it, and the experience that nearly everyone has of it, still presents every day fresh problems and fresh difficulties. The characters of typhoid pyrexia are well known. The temperature in so-called typical cases lasts three weeks, or from twenty-one to twenty-four days. It rises rather rapidly to an elevation of 102°, 103° or 104°, and then after the tenth day it tends to fall in the morning and to go down gradually in the course of the succeeding ten days by considerable oscillations, the morning temperatures dropping quicker as it were, than the evening temperatures. But the case as it comes before us for purposes of differential diagnosis presents its difficulties mostly in the first ten or twelve days. It is then, as we all know, that the characteristic signs of typhoid fever may not yet have developed. The diarrhœa, which would indicate the seat of the lesion, is sometimes entirely absent. In some cases it appears as a fugitive symptom during the first two or three days, and then disappears entirely and is replaced by constipation. The spots, which are of the greatest

value as conclusive evidences when they do appear, are frequently not seen until the 10th, 12th or 13th day. The Widal reaction, which has been recently added to our methods of diagnosis, is well known to be untrustworthy before the tenth day, and not, perhaps, absolutely trustworthy even after that. And the spleen, which perhaps is as early an indication of ill health as is likely to be afforded, is not always enlarged at this stage. And therefore we are constantly meeting with cases in which the patients have been ill with a pyrexial complaint for eight, ten or twelve days, and in which positively no help can be derived from the symptoms or any other characteristic of the case to a satisfactory diagnosis. The confusion of typhoid with malignant endocarditis is not infrequently made, and a case that I have now in Philip ward illustrates the difficulties from both points of view.

A man, æt. 23, was admitted on the fourth day of a fever, and presented a cardiac murmur, which it was obvious he had had for some time previously. The spleen was very soon enlarged, but he had no diarrhœa, and had no rose spots. Now, the condition as it presented itself then on any one day was compatible with malignant endocarditis; he had a murmur, fever, and enlarged spleen. The one thing that made us cautious about hastily coming to such a conclusion was this, that the fever was known to be only of very short duration. The diagnosis, as I have already intimated, of malignant endocarditis can only be safely based upon the temperature when the high temperature has been of sufficiently long duration to exclude the possibility of accidental pyrexial ailments of another kind. Now, this patient, although he had a murmur and had fever, was clearly not outside the scope of typhoid fever. The fever persisted into the third week, spots and diarrhœa continued to be absent, the Widal test was negative, and we continued to be in a state of uncertainty for some time longer. Then when the temperature had fallen very nearly to the normal it rose again, and within a week of this second rise some diarrhœa occurred, and a number of spots came out. That is to say, the patient had typhoid fever with a relapse ; and in the relapse there occurred those distinctive diagnostic features which the first fever had failed to show.

Tuberculosis.—I now come to another disease which one frequently has to contrast or compare with typhoid fever, namely, tuberculosis. Acute tuberculosis is very frequently first indicated by a condition of fever, and the fever may persist for a very long time, that is to say, several weeks, before any local indications of tuberculosis appear. During this time you can well imagine that the question of typhoid fever must be entertained. You will have the same anxiety to discover spots, to examine the spleen, to look for diarrhœa, as you have in actual cases of typhoid; and as the weeks pass on and no such signs appear, your difficulties and anxieties will seem to increase. I can perhaps best illustrate this point by a brief notice of two cases which have occurred to me within the last few years. One is that of a boy, 8 years of age, who was first taken ill on December 3rd, with languor, loss of appetite, and, one may say, general malaise. During the first week his temperature was not taken. During the second week it was frequently up to 101° or 102°. During the third week it was from 99° to 101°. On the 28th December he was carefully examined and no satisfactory explanation of the fever could be found. He was perhaps, rather a delicate boy, not very sturdy and robust, but not having shown any special indications of weakness; nor was there anything in his family history to justify the conviction that he must have tubercle. The fever continued during a second month, and only first on January 22nd was a doubtful crackle heard at the left base, while the apices of the lungs were perfectly clear. On February 2nd no râles were heard. On the 15th, however, there was a fine rustle at the left apex. On March 1st râles were heard in both lower axillary regions. On the 10th the râles had spread over the greater part of the lungs, and on the 13th he died.

Another interesting case was that of a male patient, æt. 31, who was seen by me on June 1st, when he had been three weeks ill. His medical man, Dr. Edwards, of Bexley, had been watching him for ten days, and he had presumably been

feverish for ten days before that. During the later ten days the chart showed a continuous pyrexia, a temperature higher in the evening than in the morning by some considerable difference. Careful consideration was given to the possibility of typhoid fever, of malignant endocarditis, of Hodgkin's disease, and of other illnesses. I particularly noted that the breathing was not rapid, the lungs were healthy, and the optic discs were healthy. A symptom which troubled him considerably was profuse sweating at night, and this profuse sweating, though occurring in typhoid fever, is certainly not generally so abundant as it was in this case. The temperature persisted very much in the same way for weeks after this, and it was only on the 1st of August, or a day or two before that, that some crepitations were heard in both upper lobes of the lungs. After this, apparently, for I did not see him myself then, the course must have been rapid, as he died a month later—on September 9th.

Thus you see that in these two cases the duration of the illness was about fourteen or fifteen weeks, that in each case the physical signs indicative of the special infection concerned did not appear until the eighth or ninth week. In both of them, the question that was constantly exercising the minds of the medical men in attendance was the question whether it was typhoid, or whether it was some other process, such as tuberculosis. The longer the fever persisted without any of the evidences of typhoid and without any indications of the termination of the first fever and the occurrence of a relapse, the more probable did it become that tuberculosis was the cause of it. But here again also the possibility of malignant endocarditis could not be absolutely excluded until the physical signs of tubercular lesions become evident.

Broncho-pneumonia.—I had intended to make the basis of my remarks the occurrence of a fever or pyrexia in which distinctive evidences of disease were almost wanting, or at any rate not conclusive of a diagnosis. But I think it may be of use to consider the question in relation to tuberculosis and the occurrence of a prolonged fever which is accompanied by physical signs of inflammatory changes in the lungs: in other words, the differential diagnosis between broncho-pneumonia and tuberculosis of the lungs in a case where prolonged pyrexia with physical signs in the chest may be thought to be strongly in favour of the latter. It must be admitted that broncho-pneumonia not infrequently brings itself within the scope of the subject which I have stated as that of my lecture; namely, it is productive of prolonged pyrexia in which difficulty of diagnosis may occur. The temperature accompanying different cases of broncho-pneumonia is very various. You may have a case of broncho-pneumonia in which the temperature rises rapidly to a considerable height, and falls almost suddenly on the fifth or sixth day. Another case of broncho-pneumonia may have a widely oscillating temperature for six or seven days, and then recovery may rapidly take place. A much larger number of cases of broncho-pneumonia have a temperature which is oscillating between 99° and 102° or 103°, and which persists for two or three weeks; but also as much as six, eight, or ten weeks. Now, during the persistence of this temperature when caused by broncho-pneumonia there are generally physical signs which demonstrate that the chest is the seat of the lesion. And then it may easily be that most of the infective processes which lead to prolonged pyrexia can be safely excluded. But there remain these two, about the diagnosis of which there may be considerable difficulty, namely, broncho-pneumonia and tuberculosis. And I may say that even typhoid fever, with an accompanying severe bronchitis, and malignant endocarditis with accompanying broncho-pneumonia may conceivably have to be considered. But the difficulty commonly lies between the two that I first mentioned. Broncho-pneumonia and tuberculosis of the lung are familiar to us as sequelæ of the infective diseases measles and whooping cough, and it is often impossible, either from the physical signs or from the condition of pyrexia, to determine which of these diseases is present, when the chest is severely involved, and continues involved weeks after the subsidence of those diseases.

Cases constantly occur in which the question has to be discussed. A patient, for instance,

has been ill four or five weeks with a pulmonary complaint, râles are heard abundantly over a large part of the chest, perhaps on one side more than the other, or it may be both sides uniformly, the temperature is oscillating in the way I have described, and there are no certain means by which we can safely determine whether one disease or the other is present. It is true that in older patients we can sometimes obtain evidence from the sputa, but in quite young children we know perfectly well that that means of observation is commonly not open to us, and consequently the diagnosis may have to be suspended until a long period has elapsed. The family history, whether for or against tuberculosis, is not to be relied upon. We commonly ask ourselves the question as the case goes on, Is this too long for broncho-pneumonia? and has the period arrived at which one must conclude that it is tuberculosis? That is a very proper way to look at it; at the same time we must remember the long duration, or the possible long duration, of broncho-pneumonia, even to the period that I have mentioned; and, therefore, we must not be too hasty in coming to alarming conclusions, or to opinions which may very much distress the patient's friends when there may actually be a chance of complete recovery before us.

A case which bears upon this point was under my care in Mary ward a few months ago, in which a girl of about seven years of age was admitted with extensive evidence of pneumonia over the left side of the chest, and partly at the right apex. The lesion on the left side was chiefly in the upper lobe. The child was very ill, emaciated, cyanosed, and had a continuously high oscillating temperature. On the basis of what I have been already saying about the persistence of broncho-pneumonia, I refused to believe that the case must be tubercular, and refused in the face of the opinions of other observers. In the fifth week of the illness the conditions were still doubtful. Very soon after that it became obvious that the physical signs were clearing up at the apex as they extended to the lower part of the lung. That was a condition which confirmed me in my view that tuberculosis, on the whole, was less likely than broncho-pneumonia, because it must be very rare for tubercle to clear up in one part of the lung absolutely while it spreads to another, and especially to clear up at the apices while it progresses at the bases. Even after this the patient became so prostrate and emaciated that for a time I was afraid she might die. But eventually she recovered, and went out perfectly well. In this case examinations of the sputum had been always negative. Other instances I might recall from the work of the hospital, but I need not further trouble you on this point. This resemblance of tubercular lesions to broncho-pneumonia is, after all, what one might expect. They are both infections, one by the tubercle bacillus, and the other by the pneumococcus and streptococci. In both the tissue changes of pneumonia are set up, the physical signs may be identical, and the toxines have similar effects. I may remind you that Addison long ago pointed out the effective lesions of phthisis were the inflammations started by the tubercle; and this fact, so well known now, explains the resemblance which I sought to bring before you.

Local suppuration.—I need scarcely refer to the very familiar occurrence of septicæmia or septic infection as causes of a high temperature. A small focus hidden from sight and almost painless, may give rise to much fever. Otitis has been mistaken for meningitis, or for typhoid fever even. I may recall the case of a child who was under observation in Clinical ward many years ago, who came in on account of acute peritonitis, from which she seemed to recover with almost unexpected rapidity. But though she was free from danger she continued ill. The temperature ranged from 98° to 100°; the child was prostrate, anæmic, failing in appetite, although apparently free from any local troubles. She continued in this condition four or five weeks. We attempted to improve her health by forcing down iron tonics, and even making her get out of bed. But these measures entirely failed to improve her. At length, some eight or nine weeks after her admission to the hospital a tender spot appeared in the abdomen, in the neighbourhood of the right iliac fossa, the skin gradually got

WILLIAM HENRY CROSSE, M.D. (Dunelm),
M.R.C.S., L.S.A., F.R.G.S.

Born September 4th, 1858. *Died February 24th, 1903.*

red ; an opening had to be made and a small quantity of pus was evacuated. I think there can be no doubt that the cause of her peritonitis was appendicitis, that the general infection subsided, and that the local disease persisted until the results found their way to the surface. As I have mentioned, there are of course numerous other cases in which persistent pyrexia is kept up by the existence of a septic focus ; but it is sufficient in the present connection to remind you that lesions of that kind must always be borne in mind when one has to deal with obscure persistent pyrexia.

I hope to continue this subject and deal with other causes of prolonged pyrexia at my next lecture.

Obituary.

William Henry Crosse.

M.D. (Dunelm) M.R.C.S., L.S.A., F.R.G.S.

There has just passed away, in the person of Dr. W. H. Crosse, a man whose transparent sincerity, upright character and lovable disposition, endeared him to everyone. Born in Norfolk, the son of a clergyman, he entered Guy's in 1876. Having lost the whole of his third year through an attack of scarlet fever, he felt it incumbent upon him to earn his own living as soon as possible, so as to relieve the financial strain upon his father. Obtaining the Licentiate of the Apothecaries' Hall, he consulted the writer of these notes as to the question of entering practice with this qualification only. Asked to explain the circumstances, there could be only one course to pursue; he at once joined, as assistant, a practitioner in the East of London, where he rapidly obtained, not only the esteem of his principal, but the confidence of the patients. Within a short time he was able to take over the entire practice, and for five years he ruled in the Isle of Dogs. Here he gained the respect of the numerous manufacturers and of the engineers. During this period he was able to assist his father very materially with the education of other members of the family, and, to the writer's knowledge, others as well. These family duties having been more or less discharged, he now sold his practice (which was worth close upon £2,000 a year) and came back to Guy's to take out the College. He entered with all the zest of a boy into the classes and passed with high commendation.

From most of his friends he now disappeared, and for several years many of us saw nothing of him—the writer could not recognise the sallow, hairless face, and the wig-covered head which he brought back from the West Coast of Africa. He had accepted an appointment on the Niger as Medical Officer to the Royal Niger Company, attracted no doubt by the salary, but chiefly, it is thought, by the life of adventure which such an appointment offered. Others could tell of the admirable work he did for this Company, becoming a close friend of its great originator, Sir George Goldie, and the other principal managers. He was in several punitive expeditions, against slavery and various hideous practices amongst the natives, on such occasions taking charge of a machine gun, in addition to discharging his medical duties.

Many who read this will recall the lecture he delivered before the Physical Society, illustrated by admirable photographs, and his almost unique collection of West African domestic and warlike implements. Many were the humorous and curious stories he told of his life in the Tropics. Three times he had blackwater fever. His indomitable spirit, and his high sense of duty, no doubt largely enabled him to resist the malady, as they have enabled him in the last few years to battle successfully with a terrible amount of ill-health. He would be carried into a boat by his "boys," having been delirious most of the night, with a high temperature, and rowed up the river in an open boat, one or two days' journey, to attend one of the Staff.

Returning to London, he was persuaded to resign the appointment, but was retained as adviser in London by the Niger Company. Upon blackwater fever he was a recognised authority, and was consulted by many of those who came from the Coast. A few years ago he decided to take the Degree in Medicine at Durham, and worked with all his old vigour, and passed well.

His practice, carried on first in Dover Street and latterly in Albemarle Street, of late had grown considerably ; he was always welcome, and, whenever sent as a substitute, he invariably did the right thing and was asked to come again. Battling with ill-health, always having some œdema of the legs, carrying about an enormous spleen, afflicted with advanced emphysema, he frequently suffered from some bronchitis.

The fatal attack began on Saturday the 14th February. On this date, though suffering with dyspnœa to an extent as to make his lips quite blue, he yet insisted on helping the writer at an important operation, and never did he administer ether more successfully than on this occasion. Carefully nursed, and watched with every care by Dr. Hale-White and Mr. Reynolds Ray, and others, he gradually grew worse. Temporarily relieved by a copious venesection, the malady progressed, and after more than three days of unconsciousness, and having endured the most terrible suffering in the early part of the illness, from "air-starvation," he passed away on Tuesday morning, February 24th, at the age of 45.

It is impossible to fill the void caused by the removal of such a remarkable personality ; others will be found to do his work, but no one can fill his place in the hearts of his friends.

Crosse found time to make observations on the birds and insects in West Africa, and was greatly pleased when Mr. Boweder Sharpe named a new species of butterfly "Euphœdra crossei."

His small brochure on "Blackwater Fever" was, when published, the best summary of the malady. Subsequently in the *Lancet* he vigorously attacked Professor Koch's view as to the effect of quinine, holding this to be the only remedy of any value. He was strongly of opinion that Koch in opposing the use of quinine had done a great deal of harm.

He re-wrote for the Royal Geographical Society the medical portion of the manual published for explorers and travellers.

His work on the blood in Malaria was well known, and he became an adept in detecting the malarial parasite, being able to foretell an oncoming attack by the appearances in the blood.

Ernest Fisher.

The sudden death of Ernest Fisher gave great pain to all who had ever met him in their visits to the Superintendent's office. He came to us in November, 1898, making his period of service about four and a half years, he proved himself to be willing and active, and therefore became deservedly popular. He was in his twenty-first year, and was of very great assistance in the general routine of the office. His illness was very brief, he being on duty up to 12 o'clock on Thursday the 12th February, when he left for home complaining of sickness and headache, he was not even in bed when the doctor saw him on Friday, and he died on Sunday morning at 6 o'clock, much to the regret of all who knew him intimately.

Dr. Fawcett went to see him in consultation with Dr. McManus, on the Saturday, but found him moribund. An inquest was held, but arriving at no conclusion was adjourned until the 20th inst., when we hope the mystery may be cleared up. The funeral took place on February 21st, at Streatham Cemetery, Tooting, and was attended by Mr. Beckwith, representing the Superintendent's Office, and Messrs. Pelling and Craske on behalf of the many officials who knew him. A beautiful wreath, circular in form, consisting of lilies of the valley, lenten lilies, white roses, and a large floche of Neapolitan violets was sent by the Sisters on the initiative of Sister Job, and Nurse Stevens on behalf of the Nurses also sent a wreath. Dr. Perry, his colleagues, and officials generally, also sent wreaths.

He had proved himself universally painstaking, reliable, and obliging. No trouble was too great for him, and nothing on his part was ever wanting in the discharge of his duties. He had made friends among all, and his loss robs us of a trusty servant. In the awful suddenness of his end, struck down in the full tide of youth, health, and strength, by a mysterious disease, we can only say

"God's finger touched him and he slept."

Correspondence.

To the Editor of Guy's Hospital Gazette.

The Supinator Longus.

Sir,—With reference to Mr. Clement Lucas' note on the Supinator Longus as a gun muscle, I would suggest that it does not take such an active part in shooting as he seems to imply, but that its hypertrophy is brought about more by a passive part, and that by simply carrying the gun while walking or standing, resting on and rubbing it. I would like to know, if in his particular instance, his right deltoid was hypertrophied in proportion, which I should imagine would be the case, as it would be equally active in raising the gun to the shoulder.

I have often found my supinator longus stiff after shooting, but have always put it down to the rubbing, as it has not been in proportion to the number of shots fired.—Yours truly, H. M. MEYRICK JONES.

Overbury, Charlton Kings, Cheltenham.

February 3rd, 1903.

Appointments.

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants.—Messrs. N. Ivens Spriggs, R. G. Anderson, B. Glendining, G. E. Malcomson, H. Tipping, B. H. Wedd.

Dressers in the Throat Department.—Messrs. S. L. Pallant, G. S. Robertson, C. H. Reinhold, K. Black, H. Watts, E. L. Ward.

Assistant Surgeons' Dressers.—Messrs. A. R. Beaumont, P. F. Minett, L. Myer, L. J. J. Orpen (Mr. Lane); R. Felton, A. Leeming, E. C. Hughes, C. M. Stevenson, E. W. Sheaf (Mr. Dunn); J. O. Musson, A. M. Roome, H. D. Wyatt, A. S. Littlejohns, S. M. Wells (Mr. Fripp); P. A. S. Dyson, R. Edridge, J. Cook, H. M. Clarke (Mr. Steward).

Medical Ward Clerks.—Messrs. N. H. Oliver, L. Doudney, R. O. Williams, H. P. Costobadie, F. M. Longson, T. Turner, F. H. Lennox-Jones, A. H. Clough, A. B. Cocker, G. F. Greening, R. P. Lewis, H. V. Mitchell, J. E. Scales, L. G. Davies, F. Alcock, C. M. Wenyon, R. A. Chisolm, J. A. C. Greene, H. M. Langdale, C. W. R. Preston, R. W. Allen, V. A. P. Costobadie, A. D. Crofts, M. C. Dickey, A. B. O'Brien, M. De L. Robinson, R. D. Barron, H. C. Cameron, F. D. Crew, R. E. French, G. H. K. MacAlister, A. Miller, M. Maher, H. McPherson, L. J. Patterson-Clavier.

Surgical Ward Clerks.—Messrs. R. M. Wingent, G. Hamilton, M. Leckie, E. H. Adams, R. J. Bentley, H. S. Knight, E. F. Milton, F. A. Sharpe, F. T. H. Wood, T. Norman, H. F. Wight, R. S. Harper, B. B. Metcalfe, W. P. Purdom, T. C. Pocock.

Aural Surgeon's Dressers.—Messrs. H. J. Gater, F. H. Wallace, D. H. Richards.

Post-mortem Clerk.—Mr. B. H. Stewart (May–June).

Passim.

The Annual Report from the Pharmacist (not so nice a title as the old-fashioned Apothecary) is very interesting reading. New brooms sweep clean, and the changes have been for the better all round. The most noticeable rise is in the patients: over seventy-thousand more attendances are recorded as compared with two years ago; but this increase is probably more apparent than real, that is, the old numbers were understated under the easier and less exact system then in vogue. The rise and fall of a drug's popularity is always interesting. Adrenalin has increased in popularity, and it certainly has a definite place in the future. Aspirin probably has too, but we are glad to see the increase in malt and cod liver oil. Potassium iodide is increasing still in popularity, but we do not expect to see urea much in the future. Pepsin has gained, and rightly, and senega has regained a lost position. The expenditure of £46 on serum gives but little return for the money; to our mind its use resembles that of musk. Among the decreases, the £100 decrease of rectified spirit is the most noticeable: and cajuput oil appears out of favour, which is rather surprising. Alginate of iron has lost favour, and so has the ferri et ammon. Cit., surely a most agreeable form of a somewhat difficult drug. Why ergot has nearly halved its consumption perhaps indicates a saner medical use, but we should have thought that Queen and the Charity were still using it greatly. Perhaps ergotinine has something to do with this. Fashion in antiseptics and dressings is hard to gauge from the list. Iodoform gauze is declining, and cyanide is rising; a commendable change. Absorbent and salicylic wool are both more used.

We think the following a little abrupt:—"A few months ago, *a larger number of deaths under anæsthetics than usual* occurred, and some suspicion was thrown on the quality of the chloroform." Rather a scathing, off-hand criticism of our anæsthetisers, but we appreciate the meaning though the expression is a little awkward. But if we remember aright, it was the increase in ether pneumonia and in the spluttering and choking that gave rise to the criticism, and we should be interested to know of the source of the ether and its standard of refinement and purity. The improvements and economies are most remarkable, and the future will show yet greater advance we feel sure.

We hear that the Obstetric Physicians are about to institute Clinical afternoons, very much on the same lines as those adopted recently by the Surgeons, and which have been so much appreciated by our students. These afternoons are undoubtedly of great value, and we can assure the Obstetric Physicians that they will be as much appreciated as those on the Surgical side are. The sooner they are started the better shall we be pleased.

Before the Summer Session commences several alterations will have taken place which may be of interest to many. The medical wards are to be deprived of their cots, which will be located in the nurses' former sick-room above Clinical, the cots and the care of them devolving on the physician in Clinical for the time being. There is no doubt that this is a great step in advance. All who pass through Clinical will have had a sound practical experience of babies and their ailments, and the children's clinique thus created will be of far greater value than the present sporadic arrangement. It will be an inestimable boon to the female patient in the wards to be relieved of the worry and wailing of other people's children. It is true that the custom is venerable and hoary with age and supported by tradition. When the system was introduced a strange sentiment prevailed that the presence of children would be beneficial to the mothers or the matrons around, and the practice throve on this extraordinary belief for many years. Much as we may regret the loss of the "tame clerk tickling the tame baby with a stethoscope," we are sure it is a most desirable innovation.

Probably before the end of this month Mrs. Walter Farquhar will set the seal on her generous donations by opening the Job ward in its beautiful and modern form. It will be remembered that

the work of restoration had perforce ceased from lack of funds and that the rehabitation of Job was the result of her individual and special generosity.

Job is really a thing of beauty and a model of a modern ward; the greatest delight of all is a *wooden* parquet floor. Of all the ridiculous fads that the aceptic theory has been responsible for the most uncomfortable was that which supposed a stone floor was essential for surgical success. The noise of the hard floor, the sore feet and great increase in wear and tear of feet, stockings and shoes, and temper, all are against them; and the idea that the debris from a carefully cleaned floor in the form of dust is any worse than the debris from dirty boots is patently absurd. The noisiness of the modern ward and passages weigh heavily against the fact that its easier to keep them clean and that there is less risk of fire. The spacing of beds is altered, also the bathroom, and the most modern arrangements are installed there at the expense of Mrs. Farquhar, who has restored the ward in memory of her husband. It is a most charming ward.

Hard upon the evacuation of old Mary by Job will come the long-awaited and highly necessary new female ward. It will cause a transformation. Above the Eye wards will be a female ward, Mary (Sister to be appointed), Drs. Taylor and Hale White. Above that and below Queen, will be the other female ward, Esther (Miss Trail, now Sister Mary), Drs. Pitt and Perry. Below Bright will be a male ward, Stephen (Miss Jones, the present Sister), Drs. Pitt and Perry, of which the part beyond the hall will probably be Dr. Pitt's and the near half Dr. Perry's. Above Out-patients', in the present Mary ward, will be the other male ward, Philip (Miss Godby, the present Sister), Drs. Taylor and Hale White, Dr. Taylor probably in the further half. There will be a total gain of 50 beds, an addition of 20 male beds and 30 female beds, most necessary of all. And so, with the exception of Bright, passes away the last of that wonderful system of beds which was in existence when most of the present generation came up, by which many and varied physicians and surgeons visited the wards. Now each Sister may expect two Seniors or two Juniors, and no others. Those who remember Dorcas in its old days will remember the chaos from which the above orderly and systematic arrangement has been evolved.

It is only fair to point out that the opening of these additional fifty beds, besides those that are opened elsewhere, is due to the grant made to us by the King Edward's Hospital Fund for London, and marks a great step to the completion of the great scheme of alteration and improvement inaugurated many years ago. The dormitories above Bright ward are being cleaned and painted for the use of the ward maids and additional lavatories are being provided.

Among other alterations that Prize Day will probably see completed is the Wills' Library and the transportation of the old books to the new building, and later the opening of the "Drunk or Dying" ward on the library site and the enlargement of Cornelius to the size of Astley Cooper, or nearly so. The new operating theatres will shortly be ready on the floor between Martha and Lazarus.

Minor innovations, but important ones, are the abolition of the Borough dame, yclept "scrubber," who will be replaced by a second ward maid, resident with the ward maids on the premises, and by this means not only will expenses be greatly curtailed, but the scrubbing will be later at night and earlier in the morning, a fact which will probably allow the women's surgery to be kept open till the surgery hours are over, say about 10 p.m.

The Cup-ties have gone and the Cup remains at Guy's and we join most heartily in the congratulations that our admirable XV. have universally earned. The Cup was not won without a stiff fight and many anxious moments. Bart's gave us a good hard game, and until we scored the game was very exciting. St. Thomas's promised us a good game and

gave it. Their big forwards, setting a great pace, kept it up with admirable dash and spirit, and a very trying time for Guy's was the result, till a brilliant field by Morgan scored our first try. But even then they were not done with, and though we managed to score again, nothing but the most resolute tackling and well-judged kicking kept them out. It recalled those dark days of their ten years' tenure, and their display was in every way worthy of their reputation and prestige, but our redoubtable outsides pulled us through after a really fine game.

Against London we played against a strong wind, and though time after time they were only pulled down inches from the line, when half-time arrived without score, no Guy's men doubted that our outsides could soon redress the balance, and so it proved. A quarter of an hour from the restart, after several attempts, two tries were scored in rapid succession, and the game was over. The most memorable features of the Cup-ties of 1903 will be the unfailing tackling and brilliant kicking of our outsides, the grand scrummage work and dash of the St. Thomas's side, and the brilliant individual efforts of the London forwards and outsides. Curiously enough we played without our two halves, but were able to fill their place without mishap.

P. F. McEvedy has been selected to play for the "Rest" and then as reserve for England v. Scotland, and Morgan has been again picked for Wales. Our heartiest congratulations on well merited honours.

We regret that to the long list of accidents we must add that which befel E. M. Harrison about the middle of the Final Tie, when a kick crushed in the malar process, which has hitherto refused to be elevated into position without an incision.

Without wishing to draw down on our heads the vengeance the gods inflict on presumption and arrogance, we cannot but point out, especially as we are about to lose some, the splendid work of our outsides. Tackling has been their strong point, their kicking unfailingly good, and their dash and combination has been shown by the scores they have made, even when against St. Thomas's the game was very greatly in our half.

It is no small matter to have kept the Cup and to have defeated the Universities of Oxford and Cambridge in the same year. Our congratulations to O'Brien, who has played his last Cup-tie, and to Harrison, the indefatigable Secretary, and to all the members of a memorable XV.

Ungracious as it is, perhaps, we must, however, point out that interest in Rugger at Guy's must not be confined to the First XV., but that the 2nd, 3rd and 4th XV.'s are important if we are to preserve our place, and rumours of slackness and want of energy and sportsmanship reach us from the 2nd XV. We hope that this will not be lost sight of.

But for the training that quite two-thirds of every 1st XV. have received in the 2nd and 3rd and also 4th XV., there would have been no return of the Cup to Guy's in 1898.

Another point is that no Guy's man has been playing for outside clubs in preference to his own, and the justification of supporting one's own club lies in the fact that McEvedy has been given a fair trial for his place on his club play for Guy's, and his appearances for his County. It augurs well for the future.

Finally, we must express our strong belief that the results have been in a great measure due to the splendid series of captains in the last years, and to the *ésprit de corp* and loyalty of the players. So mote it be.

The general practitioner, a class probably 90 per cent. of us all will eventually join, has had

his domain invaded grievously of late, though whether he will eventually regain its territory is still uncertain. The County Council Chairman and Committee have decided he knows no pathology, that he can treat pneumonias or grave abdominal disease, but cannot recognise with his eyes the lesions he has been treating, and has recommended his supersession by specialists.

The Asylums' Board recommend that the M.O.H. should be called in to sign up infectious diseases, or that some official should be appointed to assist him. This affords food for reflection, and the reflection surely should be that the clinical instruction in infectious disease is, as a rule, a farce and a sham, and ought to be made true clinical teaching, and that if the medical men do not know pathology, that the examiners must have been unusually lenient, or the teaching very poor. Certainly it is not true of our pass men.

It is, of course, absurd to suppose that a special pathologist who mistook a post-mortem perforation for a perforated gastric ulcer, and certified that death was due to overloaded intestines pressing on the heart, when he only saw the body after the organs had been taken out, it is ridiculous to suppose that such a man adds anything to the detection of the cause of death that the ordinary man overlooks, and we do not believe that the specialist detects much that the resident will miss. Causes of death from a coroner's point of view are either obvious or not at the post-mortem, there is little gradation.

But it is unsound in principle to supersede the family doctor. On him alone rests the responsibility of not being satisfied and requiring a post-mortem in suspicious cases, and if the only result of his insistence, which is almost always resented, is to see the post-mortem removed from his hands because he is incapable of doing it properly, there is little likelihood of his hearty co-operation. To take a recent instance: Would Chapman have been arrested but for the vigilance and determination of the doctor called in? Without a private post-mortem nothing could have been said unless he had reported the death to the Coroner, and by so doing have jeopardised his entire reputation, on the chance of there having been foul play, as a verdict of "natural causes" would have ruined his reputation and branded him as meddlesome and incompetent.

We would suggest that power be given to the General Practitioner to call in an expert if he finds anything he is not clear about, and we think, in point of fact, that when the ordinary conjoint man cannot on a careful post-mortem find a cause of death, in inquest cases, that it will be rare for the specialist to enlighten him. Bacteriology and chemical analysis will be required, and these even the County Council Pathologist cannot supply though he claims, *pace* Dr. Stevenson, to be a toxicologist. The Coroner's quest is for violent causes or foul play. Foul play is a matter for chemistry, and direct violence, such as a fractured scull or lacerated larynx, does not require special knowledge.

The South African Memorial must not be forgotten among the changes that our Annual Guests will notice on Prize Day next, or whatever day the Garden Party in the Park is held on. It has apparently been very quiet, but is not standing still, and its erection is now a matter of weeks.

Dr. Pye-Smith will preside at the Annual General Meeting of the Students' Club on Tuesday, March 24th, at 4 15 p.m., in the Anatomical Theatre. It is much to be hoped that members will turn up to welcome Dr. Pye-Smith and to discuss all matters on what they feel any improvements or alterations may be made.

A most successful Smoker was held on Saturday, March 7th, under chairmanship of Dr. Horrocks. It was most encouraging to find the authorities had wisely relied on our own abundant talent for the most part, though the banjo display proved extremely popular, and was a splendid exhibition of skill.

The Guyoscope, in addition to being unrepresented in its entirety at the Bodleian, is, strange to say, not represented at all in its own library. Neither in the College nor yet at the Hospital is there any representation of this genial publication, whose famed caricatures are treasured with so much care by so many students, and the copies of which are so scarce. Will anyone remember the Hospital when anxious to dispose of his bound copies and send them to us.

The Ladies' Night of the Debating Society is now approaching fast. The Committee invited Messrs. Brydone and Wrench to open the debate, and we hear Messrs. Wacher, Thompson and Black are expected to speak, so that the laughter-loving public should be satisfied. It is open to all to bring their cousins and friends, and it is hoped they will avail themselves of their privilege. The ladies' nights have lately fallen below, often far below, the level of the ordinary debates, especially since the removal to the Court Room. Let us hope their polished glory will return, though the subject is rather academic, and the debate must therefore be somewhat unconvincing. The debate is at 8 on Saturday, the 21st, in the Smoke-room.

Yesterday afternoon the Association XI. brought home on the top of an omnibus the long lost Soccer Cup, after defeating Bart.'s by four goals to one. Our heartiest congratulations.

Guy's Nurses' Choral Society and Students' Glee Club Concert.

Oh! surely harmony from Heav'n was sent
To cheer the soul when tired with human strife;
To soothe the wayward heart, by sorrow rent,
And soften down the rugged ways of life.

These lines describe very adequately our feelings on Tuesday evening, Feb. 27th. It was indeed a treat to hear Mendelssohn's music rendered as it then was. It seemed a great pity, however, to see at least half the seats empty. Surely music of such a nature appeals to a greater number than those who listened on Tuesday? It is to be hoped that the next concert will be better patronised, both for the sake of the performers and the financies of the Society.

Part I. consisted of sacred music. Nurse Petitt sang beautifully "Hear my Prayer" in her usual style. The rendering of "O rest in the Lord" by Nurse Maddison followed by the quartett, "Cast thy Burden," pleased everyone. In Mr. A. Forty the hospital has acquired one more fine vocalist to add to its already large number. The anthem, "As the Hart Pants," was alone well worth going to hear, Sister Patience singing the solo very sweetly.

In Part II. Mr. Bowle sang "By Celia's Bower" with great feeling. The cello solo by Nurse P. Dawson was the best rendered item of the whole programme, her playing being both true and brilliant. To this success she was helped by the pianoforte accompaniment of Miss Margaret Taylor, who accompanied throughout the whole evening in her usual faultless manner. Sister Rennie sang her two songs very sympathetically. Her first song, "The Fresh Violets," being especially well received. The Students' Glee Club finished the programme with "The Vintagers' Chorus," which they sang with great spirit, this last item being the best part-singing of the whole evening.

Mr. Taylor conducted with his well-known skill, and is to be heartily congratulated on the pitch of excellence to which he has this year brought the two societies. During the interval Miss Taylor was presented with a silver-mounted dressing-bag in recognition of her services as accompanist during the last four years. Miss Taylor thanked the donors in a few well-chosen words.

Royal Society of London.

MACKINNON RESEARCH STUDENTSHIP.

Two Studentships, each of the value of £150, will be awarded this year. One of them will be awarded for research in the group of the Physical Sciences, including Anatomy, Botany, Palæontology, Pathology, Physiology, and Zoology.

The Studentships are awarded for one year, but are renewable for a second year. Under exceptional circumstances they may be renewed for a third year. The Studentships are restricted to British subjects.

Applications must be received not later than June 1st.

Further particulars and forms of application can be obtained from the Assistant Secretary of the Royal Society, Burlington House, London, W.

From the Gazette's Special Pathologist.

A. E. P., Loughborough.—This sputum was free from pus and no tubercle bacilli were detected in it.

PATHOLOGIST.

Guy's Hospital.

DISPENSARY AND PHARMACEUTICAL LABORATORY REPORT FOR 1902.

The total number of Dispensary attendances by Out-Patients for the past year was 155,380. The following table shows a comparison between 1901 and 1902:—

	Medical.	Surgical.	Casual.	Free (all Classes).	Total.
1901	36,844	15,150	14,244	14,534	80,772
1902	62,361	26,206	53,106	13,707	155,380

The total receipts during these two years are as follows:—

1901 ... ... £879 18s. 6d. | 1902 ... ... £1,854 11s. 8d.

Of the total received in 1902 the sum of £1,748 11s. 1d. was from Out-Patients, £14 12s. from the Front Surgery boxes, and £91 18s. 7d. from sale of Drugs, etc. This latter amount does not represent the total of actual sales, as some accounts are paid direct to the Counting-house. The reason for the large increase in Out-Patient receipts was explained in a separate report to the House Committee last March, and it is not necessary to pursue the matter further. The new system of taking payments seems to answer admirably.

The following table gives the Monthly Returns:—

	Medical.	Surgical.	Casual.	Free.	Total.
January	3,870	1,431	1,371	1,726	8,388
February	3,036	1,164	1,214	1,501	6,915
March	4,492	1,437	2,849	1,242	10,020
April	5,826	2,316	5,007	1,025	14,174
May	5,472	2,520	4,934	766	13,692
June	4,894	2,147	4,668	893	12,602
July	6,083	2,668	5,605	1,089	15,445
August	4,902	2,509	5,326	904	13,641
September	6,028	2,750	5,773	933	15,484
October	6,138	2,560	5,817	1,085	15,650
November	6,111	2,486	5,581	1,338	15,516
December	5,459	2,218	4,961	1,205	13,843
	62,361	26,206	53,106	13,707	155,380

It should be noted that these figures are approximate only: to obtain the true figures about 20,000 should be added to the total number of Out-Patients, and £200 to the receipts.

Comparative cost of Antiseptics during 1901 and 1902:—

	Quantity used, 1901.	Quantity used, 1902.	Cost, 1901.	Cost, 1902.
			£ s. d.	£ s. d.
Acid Boric	19¼cwt.	25 cwt.	25 18 5	32 15 0
„ Carbolic	1 ton	1 ton	113 15 0	75 11 10
Chinosol	15 lbs.	12 lbs.	10 0 0	7 17 4
Cresol (Soluble)		380 gals.		23 15 0
Formaldehyde	235 lbs.	364 lbs.	7 9 11	10 13 4
Iodoform	70 „	36 „	41 9 6	31 12 4
Lysol	567 gals.	331 gals.	232 6 11	135 3 2
Glutol	4½ lbs.	5 lbs.	6 8 0	7 0 0
Mercuric Chloride	60 „	49 „	9 14 4	7 5 0
			£447 2 1	£331 13 0

This decreased cost amounting to £115 is due to:—

1. The fall in price of carbolic acid, which was very high when the 1901 contract was made, owing to the Boer War.

2. The use during the last six months of a Soluble Cresol made in our own Laboratory, which, though not so highly refined as Lysol, can be used for all ordinary purposes. It should be noted that the total quantity of Cresol and Lysol used is very much higher than in 1901, and had it not been for the introduction of Soluble Cresol, the Lysol bill would have been exceedingly heavy this year, as the cost of the quantity of Soluble Cresol used (380 gallons) is about £150.

Comparative cost of Anæsthetics during 1901 and 1902:—

	Quantity used, 1901.	Quantity used, 1902.	Cost, 1901.	Cost, 1902.
			£ s. d.	£ s. d.
Æther	680 lbs.	698 lbs.	60 4 9	62 5 2
Alcohol (Absolute)	170 „	170 „	25 7 0	26 7 1
Chloroform	550 „	560 „	43 12 9	46 9 0
Cocaine	21 ozs.	14 oz.	18 11 2	12 7 2
Ethyl Chloride	54 tubes	72 tubes	10 15 5	7 7 0
Nitrous Oxide	17,000 gals.	19,000 gals.	38 2 0	46 14 6
			£196 13 1	£201 9 11

Comparative cost of Dressings during 1901 and 1902:—

	Quantity used, 1901.	Quantity used, 1902.	Cost, 1901.	Cost, 1902.
			£ s. d.	£ s. d.
Bandages (given to Out-Patients)	306 gross	299 gross	119 17 0	112 2 6
Do. Sal Alembroth	48 „		49 10 9	6 3 0
Do. Wards (through Linen Stores)			662 5 0	681 17 6
Bandage Cloth	6,800 yds.	8,200 yds.	54 17 8	57 9 1
Cellulose Wadding	252 „	314 lbs.	5 3 9	7 3 8
Robinson Dressings	34 „	114 „	2 12 6	3 15 10
Felt Plaster	32 lbs.	62 „	12 7 0	20 12 3
Felt Poroplastic			2 2 7	4 0 4
Gauze, Cyanide	9,100 yds.	13,100 yds.	35 1 4	44 10 6
„ Grey	36,440 „	26,520 „	100 13 6	69 9 11
„ Iodoform	28,000 „	20,000 „	162 16 10	102 8 2
„ Sal Alenbroth	2,000 „	3,000 „	8 6 8	10 8 4
Holland	4,000 „	2,000 „	87 13 1	47 12 0
Lint	5 tons	5½ tons	416 0 4	363 11 10
„ Boric	17½ cwt.	19½ cwt.	83 18 8	87 16 4
Compressed Moss	34 sheets	120 sheets	2 7 3	3 0 9
Tissue (Gamgee)	252 lbs.	336 lbs.	10 11 2	12 1 6
„ (Gutta-percha)	568 „	363 „	104 4 6	65 0 3
Tow	10 cwt.	22 cwt.	9 17 3	19 3 0
„ (Carbolic)	139 lbs.	112 lbs.	2 6 4	1 17 4
Wool (Absorbent)	72 cwt.	85 cwt.	229 11 10	192 1 6
„ Grey	32 „	33 „	69 1 4	67 1 8
„ Sal Alembroth	21 „	20 „	35 18 1	76 10 10
„ Salicylic	16 „	21 „	78 18 0	91 19 6
„ Wood	112 lbs.	164 lbs.	4 2 6	6 9 10
			£2,402 7 10	£2,159 6 5

Although it would appear from these lists that less Dressings have been used, there is probably little difference between the two years, as the stock is less than when the 1901 list was drawn up. It is usual in this report to give a list of those drugs upon which the Hospital expenditure shows an increase or decrease over the preceding year.

The following lists contain only those articles where difference in expenditure is about £2:—

Increased Expenditure List.

	Quantity used, 1901.	Quantity used, 1902.	Cost, 1901.	Cost, 1902.
			£ s. d.	£ s. d.
Adrenalin and Preparations of Supra-renal Glands	2 oz.		0 7 5	15 15 6
Ammonia	662 lbs.	762 lbs.	8 3 8	9 10 6
Aspirin	none used			2 5 10
Bromine	129 lbs.	168 „	14 12 6	18 4 10
Codeine	12 ozs.	17 oz.	8 8 0	11 11 0
Extract of Belladonna	15 lbs.	40 lbs.	1 13 9	6 7 10
„ Malt	100 cwt.	92 cwt.	111 6 4	132 13 4
„ „ and Cod Liver Oil	42 „	73 „	62 16 0	110 13 0
„ Nux Vomica	62 lbs.	95 lbs.	8 11 5	13 1 9
Gentian Root	4 cwt.	11 cwt.	6 0 9	11 13 3
Gluside	40 oz.	80 oz.	4 7 1	10 16 3
Glycerin	28 cwt.	30½ cwt.	80 19 0	88 11 4
Homatropine			1 14 6	7 5 6
Iron Pyrophosphate	52 lbs.	161 cwt.	7 3 6	12 5 0
Lard	11 cwt.	11 cwt.	22 12 6	28 15 6
Mercury	56 lbs.	84 lbs.	9 1 5	11 5 4
Oil, Cod Liver	100 gals.	200 gals.	11 13 4	28 6 8
Orange Peel	36¼ lbs.	476 lbs.	7 4 1	9 8 5
Pepsin	4 oz.	96 oz.	0 15 0	5 10 6
Pilocarpine	2 „	3 „	4 0 0	8 10 0
Physostigine	360 grains	420 grains	4 13 0	7 1 0
Plasmon	44 lbs.	72 lbs.	4 13 6	9 3 0
Potassium Iodide	168 „	224 „	65 3 0	88 7 4
Senega Root	56 „	183 „	5 7 4	24 6 6
Serum (Antistreptoccic)			44 15 11	46 11 9
Soap (Soft)	1¼ cwt.	1½ tons	1 7 6	29 0 0
Solution—Formaldehyde	235	364	7 9 4	10 13 4
Trional	6 oz.	24 oz.	0 16 0	3 6 6
Urea			0 9 0	6 13 11
			£506 3 10	£767 10 10

Decreased Expenditure List.

	Quantity used, 1901.	Quantity used, 1902.	Cost, 1901.	Cost, 1902.
			£ s. d.	£ s. d.
Ammonium Benzoate	12 lbs.	15 lbs.	4 10 8	2 2 11
Acid Citric	93 „	34 „	6 18 10	4 9 10
Atropine Sulphate	14 oz.	4 oz.	5 5 0	3 0 7
Balsam of Peru	47 lbs.	27 lbs.	15 16 2	8 18 9
Bismuth Salts	130 „	150 „	45 4 8	42 17 9
Camphor	299 „	278 „	33 3 10	29 14 6
Carbon Dioxide	69 cyl.	42 cyl.	13 3 0	7 17 6
Creosote			7 12 0	4 10 10
Extract of Cascara	236 lbs.	281 lbs.	18 7 4	15 2 9
„ Ergot	279 „	203 „	41 18 10	24 14 10
„ Henbane	18 „	12 „	7 4 0	1 12 10
Guaiacol	78 oz.		11 18 3	6 18 3
Iron and Ammonium Citrate	140 „	102 oz.	9 3 2	6 3 11
„ Quinine „	63 „	42 lbs.	32 6 3	13 11 11
„ Alginate	41 „	22 „	33 6 0	17 14 5
Honey	27½ cwt.	19¾ cwt.	34 11 4	20 2 10
Lead Oxide	406 lbs.	224 lbs.	4 13 7	1 16 0
Magnesium Sulphate	10¾ cwt.	9 cwt.	7 14 4	2 14 2
Morphine	32 oz.	16 oz.	7 12 0	3 6 6
Musk	3¼ „	1 „	8 6 9	4 6 3

Decreased Expenditure List—continued.

	Quantity used, 1901.	Quantity used, 1902.	Cost, 1901.	Cost, 1902.
			£ s. d.	£ s. d.
Oil Cajuput	18 oz.	7 oz.	4 5 3	1 3 8
„ Eucalyptus	24 „	17 „	3 5 9	1 4 4
„ Lavender	29 „	6 „	5 0 0	1 5 0
„ Olive	370 gals.	250 gals.	60 10 6	42 0 10
„ Sandal Wood			12 10 0	9 0 0
Potassium Bromide	294	210	26 4 10	17 18 1
„ Citrate	203	189	13 4 10	10 15 3
Quinine Sulphate	250 oz.	220	18 17 1	13 9 9
Opium	73 lbs.	74 lbs.	39 8 11	35 9 0
Oxygen	23,000 gals.	28,000 gals.	90 0 0	57 19 6
Sarsaparilla Root			7 7 0	2 5 6
Silver Nitrate	43 oz.	36 oz.	5 12 1	3 1 1
Sodium Salicylate	182 lbs.	140 lbs.	19 16 2	10 0 8
Solution of Bismuth	203	141 „	5 3 7	3 5 1
Spirit Rectified	400 gals.	300 gals.	395 0 0	296 0 0
„ Ammonia, Aromatic ...	1,426 lbs.	1,470 lbs.	129 3 8	120 15 4
Syrup, Easton's	195 „	32 „	4 10 2	0 15 1
„ Virginian Prune... ...	167 „	13 „	7 8 11	1 2 0
Sugar	36 cwt.	30 cwt.	29 15 0	25 17 2
Turpentine	170 gals.	190 gals.	27 0 10	23 11 8
Urotropine	14½ lbs.	None bought	9 16 1	
Bottles			72 17 9	61 19 7
Labels			26 8 0	20 13 0
			£1361 12 4	£981 8 6

Decrease Drugs	£380 3 10
„ Antiseptics	115 9 1
„ Dressings	243 1 5
	£738 14 4

In 1901 there was an increase of £674 5s. 10d. over the previous year, whence it appears that the expenditure in 1902 is about £54 less than 1900.

Notes on Increased Expenditure.

The reason for increased expenditure seems to be due to increased consumption, except in the case of Extract of Malt, where less has been used at an increased market value. Pilocarpine advanced in price from 40s. to 75s. per oz.

Gentian Root.—7 cwt. has been used for Compound Acid Mixture, of which over 3000 gallons have been made.

Note on Decreased Expenditure List.

It will be noted that in the case of Oxygen, while the consumption has increased and the cost has decreased £32, the actual saving has been £51. This is due to the fact that better terms were made with the makers than had hitherto obtained with the agents who had supplied the hospital for many years.

The same remarks apply to Bottles. The hospital was being served by a firm which had supplied bottles for many years, and was still charging the same prices, and the bottles we were buying at 21s. per gross we now buy at 13s.

In the case of Easton's Syrup, Syrup of Virginian Prune, Urotropine and some other drugs, we have commenced to make these in our own laboratory. *Spirit Rectified.* The decreased consumption, which is larger than shown as our stock is greater now than this time last year, is due to the fact that formerly in dispensing, where infusions were ordered, a certain proportion of tincture of the same drug was used. Also, instead of making chloroform water in the usual way, a corresponding amount of spirit of chloroform was used, both methods being very wasteful and to be strongly deprecated.

Pharmaceutical Laboratory.

The work of this department during 1901 and 1902 has been as follows:—

	1901.	1902.
Pills	597,000	668,000
Ointments	5,796 lbs.	5,880 lbs.
Strapping	14,450 yds.	14,750 yds.
Plasters (various)	680 yds.	890 yds.
Syrups	1,386 gals.	1,510 gals.
Tinctures and Liquors ...	No record.	350 gals.

All these show an increase consistent with the fact that a larger number of patients—In-patients and Out-patients—have been provided for. The quality of the

drugs has been, on the whole, good. I have made numerous analyses, but in only three cases have the samples departed from the required standard. In one case—Honey—the consignment was immediately sent back. In one sample of Compound Syrup of Phosphate of Iron a portion of the phosphoric acid had been replaced by the cheaper Hydrochloric Acid. In one sample of Liquid Extract of Ergot the full amount of Alcohol was not present.

A few months ago a larger number of deaths under anæsthetics than usual occurred, and some suspicion was thrown on the quality of the chloroform used in this hospital. In every case the article was found to answer the very stringent tests of the British Pharmacopœia.

A feature in the last year's work has been the extension of the manufacture of various preparations in our Laboratory, instead of buying them as heretofore by Contract. This has been undertaken for the reason that we can make most of the preparations of the Pharmacopœia at a cheaper rate than they can be bought; also it is simpler to ensure the quality of the crude products than the manufactured article; for example, it is easier to test the quality of the phosphoric acid than to estimate fully such a preparation as Compound Syrup of Phosphate of Iron or Easton's Syrup into which it enters, and which can be made by a dispenser in far less time than it would take me to fully analyse the same. Also in this way it is hoped to preserve Pharmacy from becoming a lost art, so far as this hospital is concerned.

An Out-patient clerk has been appointed, who is responsible to the Pharmacist for all money taken from Out-patients, and who also assists in the clerical work of my department.

Various changes have been made to lessen the chances of error in dispensing.

Some months ago, a patient was admitted into Clinical ward suffering from poisoning. The preparation had been obtained from the Dispensary, and, following the old custom, no insistence had been made that this should be put into a proper poison bottle. Since then I have drawn up stringent rules on this point, and it is hoped no such accident will again occur.

In connection with the supply of proper bottles to Out-patients, it has seemed desirable to suggest that, when a change is made in the bottle-stall proprietorship in the Out-patient's department, the Dispensary should have control of it. At present it is often necessary to exercise a little charity in the case of a destitute patient, Also the profits accruing would probably yield £100 to £120 a year to the Hospital funds.

A better system has been adopted for recording the work done in the Laboratory, and this should prove useful when a new edition of Guy's Pharmacopœia is brought out, as it will show exactly which preparations are in use.

Instead of each department buying exactly what is needed for its own use it is suggested that, where the same materials are required in several departments, there shall be one transaction, and thus better terms may be made with the manufacturers than could otherwise be obtained.

At my suggestion the Medical School now obtains through the Dispensary various materials which are bought largely by this department, *e.g.*, formalin, etc. The same plan obtains with various departments of the hospital, but no attempt at systemisation has yet been made. For instance, this department used 1½ tons of soft soap in 1902, and this year will probably require more. The Superintendent's Stores required 5½ tons. Now if we could add these together and go to the makers we should almost certainly be able to get better terms than either department individually.

I should like to draw attention to the method of storing and distributing methylated spirit in the hospital. At present it is placed in the Superintendent's Stores in a cellar, which inspection does not convince one is suited for the purpose. It is carried to the Dispensary, and then distributed to the wards, a process which involves unnecessary labour. It is suggested that it should be kept in a place specially set off for inflammable liquids, preferably in the Dispensary Department where it is required to store other inflammable substances, and for which at present no special provision is made.

HORACE FINNEMORE, A.I.C.,
Pharmacist to the Hospital.

Sport.

Rugby Football.

GUY'S v. ST. THOMAS'S.

Inter-Hospital Rugby Cup.—Semi-Final.

(Guy's, 6 points; Thomas's, Nil.)

Played at Richmond, Friday, February 27th, 1903, before a large number of staff and students of either hospital. Guy's won the toss and defended the golf links. From the outset Thomas's pressed and early displayed some brilliant forward work. Packing quickly and breaking up smartly they swamped our defence and the first twenty minutes went by with a continuous and dangerous pressure on our defences, chiefly within our twenty-five. Tolhurst kicked off and the game settled in our half. Harrison relieved with a kick to half way checking a strong forward rush. Cutler relieved further pressure. St. Thomas's three-quarters were getting the ball well and gained much ground and the outlook was very black owing to the marked superiority forward and the constant openings their halves gave the outsides. From a scrum just outside our twenty-five, Cutler passed to O'Brien, who transferred to Orpen, who threw a long high pass towards Morgan. Morgan fielded it magnificently at the half volley, and in a few strides was clear of his wing, and evading a large number of men cutting across, he raced from our half across the line in the far corner, just grounding the ball before being

surrounded after a long and brilliant run. The disorganisation was due to their being lined up for defence, and nothing but the beautiful way the pass was fielded made the try possible. Tolhurst failed at a difficult kick. Encouraged by this, another round by Cutler, O'Brien, McEvedy and Alcock resulted in the latter being brought to earth in their twenty-five, but their forwards again relieved. McEvedy broke through and running strongly passed to Morgan, who essayed a pretty drop, but a touch down resulted. Anderson and Saunders brought the game back to the Thomas's goal line, but the Thomas's forwards again cleared splendidly. Smart passing by all the outsides almost let McEvedy in. Thomas's then brought the game into our half, but a beautiful kick by Harrison found touch well in their twenty-five. The forwards were now more alive to the work and getting the ball, but it hung in the second row badly A free kick to St. Thomas's made them dangerous again, but Orpen saved, and the forwards dribbling well brought the game to mid field. Several bouts of passing ensued, but the Thomas's outsides were not passing well and several opportunities were lost. Cutler, Alcock, McEvedy and Orpen, who returned to McEvedy as Morgan was being marked, and a score was just averted. A dangerous rush by the Thomas's forwards, who overwhelmed our halves who were hesitating, was just saved by Alcock. Good punting by O'Brien and Thompson, Pinching and Saunders, led to another attack in their twenty-five, but their forwards, wheeling the scrum beautifully, came away with the ball, only to be checked by a splendid save by McEvedy. Two free kicks were awarded to Thomas's for offside. Even play followed up to half time.

GUY'S ... ... 1 try (3 points).
THOMAS'S ... ... Nil.

Following some even exchanges, a free kick was given to St. Thomas's, but from a scrum in our half O'Brien kicked to their twenty-five flag. Thomas's forwards, playing an exclusively forward game, carried the ball back, but Cutler, O'Brien and Orpen enabled Alcock to run well into the Thomas's territory. Guy's but seldom got the ball, and Ward, Tolhurst and Alcock had to save in quick succession. Orpen broke through at half-way, and after running kicked high, with McEvedy backing up. All three arrived on the ball at the same moment. Orpen waited for the back to gather the ball, slung him as he started to clear, and McEvedy picked the ball up as it dropped—a very pretty piece of play. O'Brien's kick failed. Orpen returned the kick, kicking across, and Morgan dashed through and tackled the man with the ball, but Thomas's forwards saved again. Cutler was now playing very well, defending doggedly and opening the game smartly. The three-quarters passed well, and Alcock nearly broke clear. Pinching was conspicuous in the line-out. Later, O'Brien made a good opening for Alcock, who rushed well into the twenty-five. Several forward rushes were stayed by Morgan and McEvedy, and Harrison kicked well. The game remained fierce and fast up to the finish, when Thomas's almost scored, but the game resulting :—

GUY'S ... ... 2 tries (6 points)
THOMAS'S... ... Nil.

Guy's.—E. M. Harrison (back) ; E. Morgan, L. J. J. Orpen. P. F. McEvedy, F. Alcock (three-quarters) ; A. B. O'Brien, F. Cutler (half-backs) ; R. G. Anderson, B. Glendinning, E. L. Ward, A. R. Thompson, S. M. Saunders, W. G. Pinching, E. H. B. Milsom, H. M. Tolhurst (forwards).

GUY'S v. LONDON.

Inter-Hospital Rugby Cup.—Final Round.
(Guy's, 11 points; London, Nil.)

By winning this Cup Tie, which was played at Richmond on Wednesday, March 4th, Guy's gained the Cup for the third year in succession. Although the morning was cloudy and rain threatened, in the afternoon the sun broke forth, and when the teams took the field the ground was in excellent order. A strong breeze was blowing across the field, giving great advantage to the defenders of the golf course end. Amongst a large and keenly-interested crowd it was pleasant to see so many of our Staff present and also numerous old Guy's men.

Having won the toss, London entered the field at 3.10, soon followed by Guy's who defended the entrance end. The first half resulted in very even play, London, on the whole, having the advantage, and many anxious moments were experienced by Guy's supporters. Excellent defence, particularly by Morgan, McEvedy and Harrison, however, prevailed, and at half time there was no score to either side. In the second half, Guy's quickly got the upper hand, and when no side sounded were leading by 1 goal and 2 tries to nil.

Tolhurst kicked off, and play opened in London territory, but their forwards, carrying the first few scrimmages and showing good footwork in the loose, soon put Guy's on the defensive. A good left-foot kick by O'Brien, a forward rush in which Milsom was conspicuous, and a fine tackle of Crimp by McEvedy, in quick succession, relieved, and just when about to look dangerous, a series of mistakes led to several exciting scrimmages on the Guy's goal line. Sterling work by the forwards and McEvedy averted the danger and transferred play to midfield. Following further play in Guy's territory, the forwards got the ball often, but the halves, Cutler especially, were slow in getting the ball away. McEvedy broke through, and Alcock tackled Gibson well; Saunders, supported by O'Brien, dribbled through to the twenty-five. Later, O'Brien kicked high and Alcock collared Crimp, who delayed too long, and tried to dodge ; a scrum followed beneath the post, but London kicked dead, and from the scrum that followed dribbled to our twenty-five. Anderson broke away from the line, and following a pretty bout of passing, Milsom and Saunders dribbled to half-way. Some wide passing by the three-quarters lost ground. Glendinning and Milsom carried the ball over, but lost it, the referee not having noticed a forward pass. London rushed down, but Cutler defended splendidly, also Harrison, who saved an ugly rush and kicked far to half-way; Morgan kicked beautifully into touch. O'Brien dribbled to the twenty-five ; then Cutler got the ball out smartly, and Morgan dashed off, the ball travelling rapidly along, but the London defence was unfailing, and Alcock was just collared. Alcock and Pinching were next conspicuous, and O'Brien made his mark and tried to drop a goal; but Crimp, weakly dallying, was well collared by Orpen, and a score nearly resulted. The London forwards then dribbled splendidly and swept down into our twenty-five, but McEvedy and Harrison again saved a nasty attack. The London three-quarters had some dashing attempts, but a long free kick by Harrison relieved the pressure. Cutler was now getting the ball well out, and the attack was strong, but the London defence was keen and unerring. Morgan saved twice well. Crimp, almost in, was heavily grassed by Alcock. Harrison again relieved. Crimp, again nearly in, was again tackled on the line by Orpen. O'Brien punted well, but half-time arrived with London in our half.

GUY'S ... ... Nil.
LONDON ... ... Nil.

After half-time, McEvedy broke away and kicked well into touch; the forwards swept down, Glendinning, Saunders and Anderson showing well, but a free kick averted the danger. McEvedy made a good drop at goal. Nicholson intercepted a pass and Gibson got clear; Morgan tackled him well. A rush into our twenty-five was met by a long kick from Harrison with the wind. Alcock kicked high and bore down on the full-back, and tackled the three-quarter in the twenty-five. Ward, Glendinning and Pinching were conspicuous in a forward rush, and following a brilliant tackle by McEvedy, a hard scrimmage on the London goal line followed. Play was transferred to the Guy's twenty-five, but a grand kick after a smart pick-up found touch inside the London twenty-five. O'Brien dashed through, and, swerving sharply, was just downed; Crimp, swerving too, hurt himself for a few minutes. Two more attempts to break through were frustrated, the ball not being passed out quickly enough, and Orpen was just held. Cutler sent it sharply to O'Brien, who quickly set Orpen going, and a smart pass to Morgan opened the score amid terrific enthusiasm twenty minutes from the re-start. Tolhurst made a good effort. Tolhurst kicked over, and a touch down. O'Brien punted high and a scrimmage on the goal-line followed. O'Brien gave Alcock a fifteen yards' dash which, despite many attentions, he accomplished in his most forceful style, and Tolhurst converted with a good kick. McEvedy was then again conspicuous, and the attack was very hot. The forwards were playing well, and wheeling the scrum, cleared an attack out of our twenty-five. Glendinning broke from the line-out, and with Saunders dribbled into the twenty-five. O'Brien made a mark, but a good drop went wide. Glendinning and Thompson were again conspicuous, and Alcock just missed a try; Cutler, O'Brien, McEvedy and Orpen ended in Orpen being well tackled, and two touch-downs ollowed. Alcock again returned with a good kick. Thompson broke away, dribbling neatly, and Cutler getting the ball out, it went to O'Brien, Orpen and Morgan and another try was scored. Tolhurst again kicked well, but unsuccessfully. Saunders, Thompson and Ward rushed well, and McEvedy again tackled Crimp, and another touch-down followed. The game became one of dash and tackle; Alcock made two characteristic runs, but his opponents were undaunted, and after Ward, Harrison and McEvedy had been conspicuous, the game ended:—

GUY'S ... ... 1 goal 2 tries (11 points)
LONDON ... Nil.

Guy's.—E. M. Harrison (back); E. Morgan, L. J. J. Orpen, P. F. McEvedy, F. Alcock (three-quarters); A. B. O'Brien (captain), F. Cutler (half-back); R. G. Anderson, B. Glendinning, E. L. Ward, A. R. Thompson, W. G. Pinching, E. H. B. Milsom, S. M. Saunders, H. M. Tolhurst (forwards).

Remarks.—All played well, and no one was below his usual standard. Harrison has never played better, his tackling, fielding and kicks being most invaluable. The three-quarters were poor at the start, they hung on too long and passed poorly, perhaps due to the wind, but the unerring tackling of Crimp by McEvedy will live in our memories and probably in his. Alcock never released anyone, and was most serviceable in the first half. Morgan was brilliant. In the second half the passing was beautiful and well-timed, and the scores were the result of real merit. Morgan showed best in speed, but Orpen showed great judgment. Cutler improved after a slow start, and as he and O'Brien began to be smarter in passing he played a really fine game. O'Brien's kicking and dribbling and passing after the first quarter were all that could be desired, and he made several good openings. Of the forwards all were conspicuous at one time or other. They showed skill and dash, and their only fault was that they did not support the individual rushes sufficiently and the ball hung a little in the second row. Tolhurst's place-kicks were splendid. Glendinning, Pinching, Ward and Anderson were, perhaps, the soundest all round, but their foot-work and dribbling were really excellent, particularly Saunders. The play of the lighter London forwards was rather a revelation, some of their work being quite first-class, but there were weak points elsewhere.

Reviews.

Refraction, a Simple and Concise Treatise on Practical Sight Testing. By Guy E. Druiff. (Anglo American Optical Company). Pages 300, with illustrations.

The prescribing optician, like the prescribing chemist, is always with us. In a review of a book of this sort, obviously written from the stand point of the optician only, we cannot let this fact escape our notice. On the other hand, so universal is the practice becoming for opticians to depend upon advertisement for their customers, and not upon the medical profession, that any attempt to protest will probably be useless. Mr. Druiff's book is unmistakeably written for the prescribing optician and suffers accordingly in parts.

The anatomical portions of the book are very scanty and might have been omitted without loss; the use of atropine cannot be discussed for the optician cannot use it, and the possibility of finding out the true cause of a failure to achieve normal vision is beyond the reach of any one who might read the book.

The chapters on practical sight-testing, by means of test-glasses, relying on the patients' statements, with the occasional use of the ophthalmometer, are quite satisfactory and correct. Retinoscopy, the oculist's chief and most reliable method of determining the refraction, cannot be carried out as atropine cannot be used. Under these circumstances, Mr. Driuff's methods are as careful and accurate as could be desired, and the optician following his directions can make no serious mistake.

The chapter on "Transposing," a new feature of the book, would be of course unnecessary to the oculist.

The directions throughout for the correction of muscular errors, the treatment of squint by glasses, and the choice and accurate fitting of frames, are very complete and practical, and the type and diagrams are both of a very high standard.

The book should prove extremely useful to all opticians who wish to prescribe as accurately as possible for patients who may seek their advice.

Marriage.

MOORE—NOLAN.—On February 11th, at Cairo, Egypt, Cecilia Eva Gladys de Redclyffe, eldest daughter of Beaufoi Moore, of the Middle Temple, and Ashington, Essex, Barrister-at-law, and of Mrs. Beaufoi Moore, to Harold Nolan, LD.B., M.B. Lond., F.I.C.

Death.

CROSSE.—On February 24th, at his residence, 37, Albemarle Street, W., William Henry Crosse, M.D., F.R.G.S., late P.M.O. Royal Niger Company, the beloved son of the Rev. Marlborough Crosse, Vicar of Terrington, Norfolk, aged 45.

Ed.—J. M. B.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

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The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING AND SIXPENCE.

Calendar of Coming Events.

Mar., 1903.

Sat. 28.—Messrs. Symonds and Stewart's take-in; Drs., H. H. Carter and B. Moiser; Cl., E. Faulks.

Mon. 30.—Second Test Exam. for L.D.S., Eng.

Tues. 31.—Preliminary Science (L.D.S.) Examination.

April.

Wed. 1.—May Appointment List opened.

Thur. 2.—Messrs. Lucas and Lane's take-in; Drs., H. H. Jenkins and M. G. Louisson; Cl., B. H. Wedd.

Second Conjoint Exam. begins.

Fri. 3.—Test Exam. for 1st Professional Exam. for L.D.S., Eng.

Tues. 7.—First part of Camb. D.P.H. Exam. begins.

Cambridge 3rd M.B. Schedules to be brought to Medical School Office for signature.

Wed. 8.—May Appointment List closed.

Thur. 9.—Messrs. Golding-Bird and Dunn's take-in; Drs., A. E. F. Kynaston and R. M. Beadnell; Cl., N. I. Spriggs.

Easter Number of GAZETTE published.

Fri. 10.—Good Friday. Medical School Office closed.

Guy's Hospital Gazette,

MARCH 28, 1903.

The Differential Diagnosis of Cases of Prolonged Pyrexia.

TWO CLINICAL LECTURES BY DR. F. TAYLOR.

LECTURE II.—February 28th, 1903.

GENTLEMEN,—I may remind you that at the last lecture I was discussing the diagnosis of cases in which pyrexia of long duration, perhaps ten days or two or three weeks or longer, was present, and in which the usual means of distinguishing one disease from the other were not readily available. I considered then malignant or infective endocarditis, of which the two cases are still in the wards; typhoid fever; tuberculosis; and broncho-pneumonia and septicæmia.

In continuation of this subject I will next call your attention to a form of pyæmia which is extremely rare, and of which I recently published a case in the last volume but one of the Guy's Hospital Reports, namely, Suppurative Pylephlebitis. It has frequently been mistaken for other diseases, infective and otherwise. It has especially been mistaken for typhoid fever, and therefore it very well comes within the category of our present subject. I show you a temperature chart of this case covering a period of four or five weeks.

In suppurative pylephlebitis we have an infection within the portal area, secondary to septic processes and lesions in any part of that area, such as appendicitis, pus in the female pelvic organs, gastric ulcer, or any other suppurative lesion within the abdominal area, that is to say within the range of collection of blood by the tributaries of the portal vein. A suppurative thrombosis of the portal vein is thus caused, the liver is thereby infected, and numerous abscesses form in that organ. In the article of which I have spoken I was able to give a coloured illustration, showing the occurrence and distribution of a number of small abscesses in the substance of the liver.

You might perhaps think that the diagnosis ought to be relatively simple, and yet it is curious how extremely difficult it is, and how frequently cases have died without a true diagnosis having been arrived at. That difficulty arises, I think, mainly for these reasons:—

First, the original lesion, that is to say, the suppurative focus which is the cause of the infection may be entirely concealed; and we know how obscure the condition of appendicitis sometimes is.

Secondly, there may be no sign in connection with the liver to indicate that it is the seat of a suppurative process; except perhaps a little tenderness, and even that may be extremely slight. The enlargement of the liver which is present in some cases of this condition is absent in others; and jaundice is very often wanting.

In such a case, as in the one I have narrated, you may be left with the fever as nearly the only symptom. Now, the fever, as you will see from that chart, was a prolonged one. You will see that rigors frequently occurred; and in the persistence of the temperature and the presence of rigors were shown the high probability that a pyæmic process was at work; though in the early stages there had been features which justified a suspicion of typhoid fever. But the point I particularly want to call your attention to is, that just as in malignant endocarditis where you have a septic process like that of pyæmia, so in pylephlebitis, you may have an entire absence of signs by which your attention can be directed to the seat of the disease. The original lesion may be obscured, and the disease in the liver may not be of such a kind as to direct your attention especially to that organ. In that case therefore you are left with the fever upon which to form your diagnosis; and you are placed in a similar position to that in which you are when attempting to distinguish typhoid fever from other septic processes.

Now, with regard to rigors being a distinctive element in these cases, the difficulty with regard to pylephlebitis is very similar to that with regard to infective endocarditis. Rigors are sometimes present, and sometimes they are absent for long periods, and the reason for the variations is not obvious. In a case of malignant endocarditis which I had under my care a few years ago, and which we had under observation four weeks, the patient had frequent rigors in the first two weeks, but in the remaining two she had none. I do not think there was any feature in the case which gave us a sufficient explanation of this difference in the course.

Influenza.—This disease often presents considerable difficulty in the present day. I do not know how far some of you can go in the history of medicine, but influenza not very long ago was a disease of which many of us knew practically nothing. Some of my seniors no doubt saw influenza in the years 1847–1848; but since then, up to the last month of the year 1889 influenza was generally regarded as a thing of the past, and the word was only used as a qualification for a very bad cold in the head—an "influenza cold";—and the complaint was not recognised as a separate entity, a separate disease, in the same way as it is now. Up to the year 1889, if a patient developed an obscure fever, it was usual to speak of it as gastric fever, or low fever; while in the hospitals it was frequently written down as "? typhoid." I think you will be able to find a number of the reports in the old volumes in the medical registrar's room bearing this title, or "pyrexia, ? typhoid" or "Febris?"

Probably many of those were mild cases of typhoid, and if they were not we have now no means of knowing what they actually were. But at the present time, when influenza has come among us as a more or less definite disease, of which the micro-organism is recognised, if a patient has an obscure fever the cause of which is not at first obvious, we have to consider the possibility of its being influenza; and in cases which are thought to be typhoid at first but recover quickly, without confirmatory evidence of typhoid, the influenza bacillus has to be taken into account as a likely source of the complaint. You know that in what is considered to be typical influenza there is a fever of very short duration, with a temperature reaching to 103° or 104°, lasting one or one and a half days, and then rapidly subsiding.

Such a short, intense pyrexia, was almost universal in the first modern epidemic, that of 1889 and 1890. The cases were remarkable for their acute onset, with fever and prostration, and for the quick recovery of the patient. But since that date a great deal of variety has occurred in the cases, and it must be admitted that the high temperature does not always limit itself to such a short period as I have mentioned, but is continued for five or six days or more.

When in a case of this kind the high temperature has persisted for more than six or seven days, the question of influenza has to be reconsidered, and the possibility of some other infection has to be thought of. This difficulty is constantly arising, and so far we have few means of determining whether the disease is influenza as a rule, except by the exclusion of other ailments and certain points in the mode of onset, locality of the pains, on which little reliance can be placed. Supposing a fever of this kind continues till the ninth or tenth day, you have got to determine whether there are any local evidences of pneumonia or pleurisy, or the familiar signs of typhoid fever, such as rose spots, enlarged spleen, and perhaps the Widal reaction. Hitherto in ordinary practice that is virtually the only way we have to proceed.

In exceptional cases, the bacillus of influenza may be discovered, especially in the sputum and other secretions from the patients; but I think I am right in saying that that method of detecting influenza within the first few days of its occurrence is not applicable in general practice, nor is it even widely applicable in hospital practice.

Syphilis.—I now come to another infection, and that is syphilis. It has long been known that the temperature may be raised in syphilis, especially in the secondary stage, that is to say, at the time of the eruption when we know that the toxine of syphilis must be diffused throughout the body.

It is not so in every case, however. Mr. Hutchinson, in his work on "Syphilis," says, "Severe pains in the joints occur, or loss of appetite, and failure of strength, and above all a very marked rise of temperature every evening. These indications of constitutional disturbance are sometimes quite out of proportion to the skin eruption and other local conditions." And I have here an article which was reprinted from the New York Medical Journal, of June 22nd, 1901, by Dr. Futtcher, of Baltimore, on the subject of syphilitic fever, with a report of three cases, and he refers to various authorities on this subject. He says it may occur in very rare instances, so long as three or four weeks before the onset of the secondary skin eruption. This early fever is puzzling and likely to be attributed to some other cause until the eruption makes its appearance. The occurrence of the fever, he points out, may be unaccompanied by any indication of what is the source or nature of the infection. And, of course, if there is any concealment in this matter on the part of the patient, it renders the task of the physician harder than it would otherwise be. The onset of the temperature may precede, or it may be coincident with, the appearance of the secondary eruption. Dr. Futtcher refers to a case in which it appeared that the temperature occurred so long as twenty-nine years after the disease was contracted. As a matter of fact, in this case the gentleman had actually forgotten the occurrence of the disease. The author further points out that it may be a mild continued pyrexia, or a remittent type of pyrexia, or thirdly, a definite intermittent fever. I show you a chart which was published with one of his cases extending over four or five weeks, a chart which might easily be mistaken for one of phthisis or malignant endocarditis, or broncho-pneumonia. This conclusion, as you might expect, is to remind us all that in cases of fever of obscure origin the possibility of its being syphilitic should be borne in mind. The author says, experience has shown that physicians of reputation, as well as those of limited experience, are prone to mistake the condition for one of the acute specific fevers, the affections with which it is most often confounded being malaria—and you must remember that in America malaria is much more common than it is in this country—tuberculosis, sepsis, and less often rheumatic fever. The above remarks, you see, refer chiefly to the early fever of syphilis or the fever of the secondary stage.

In the Clinical Society's Transactions for 1884, a case is reported by Dr. Yeo, with the title "A Case of Pyrexial Syphilis." A chart published with the case showed a temperature oscillating between 98° and 103° or 104° for more than four weeks; and this fever began three weeks before the secondary eruption. Dr. Yeo says the case appears to be of interest, "because it would seem to be very rare in ordinary medical practice to encounter in acute pyrexia of this description as a part of the phenomena of an early stage of syphilis."

That congenital syphilitic lesions may be accompanied by a remittent or intermittent fever is shown by a case which was published by the late Dr. Bristowe in the Clinical Society's Transactions for 1866. A boy, aged 15, came under his care with a swelling in the epigastrium, which was obviously connected with the liver. He had a well marked remittent temperature. The chart which I show you represents the temperature for the last six or seven days of the fever. The morning temperatures range between 96° and 98°; the evening temperatures between 101° and 102·5°; and this febrile condition had been going on for four or five weeks. At first no facts could be elicited from the patient in favour of syphilis, and the idea was dismissed from the observer's mind. Subsequently on careful enquiry it appeared that three brothers and sisters had died young; that the patient had had some affection of vision at seven years of age; and an examination of the eyes showed specific keratitis. The idea that the swelling of the liver might be a gumma was again entertained. This led to the administration of iodide of potassium; and quite moderate doses, five grains three times a day, were given, with the result, shown in the chart, that the temperature dropped in four days to the normal; the patient progressively got better, and was discharged very nearly well.

In 1899 I had a case which was very much like what Dr. Bristowe's seemed to be. It was that of a young man who was in the artillery band at Woolwich. He had a swelling of the liver with some fever. The swelling of the liver was rather obscure; and it might have been a gumma or a hydatid. I gave iodide of potassium in 10-grain doses. The fever and the swelling subsided and the patient went out well. It is true that he absolutely denied syphilis, but it is possible that this also was a congenital case. From the existence of a local swelling in the liver, these last two cases are not strictly within the limits of the cases of pyrexia which we are considering.

Hodgkin's disease.—Now I come to another class of cases. All the cases hitherto have been of a septic or infective nature, and you might well say that they are only illustrations of the fact that many, indeed most of the infections which occur in the human subject are accompanied by fever; and you might suggest that if that is borne in mind, it is an easy matter to work out the distinctive features of each. But what I have paid special attention to in this and in the last lecture is in separating and calling your attention to that group of pyrexias which is characterised by long continued fever, those which do not show very much, and which are not accompanied by distinctive features, or in which the usual distinguishing features may be absent at the time.

In the group of cases to which I now call your attention, it is conceivable that infection may be the cause, but so far their infective nature has not yet been proved. An instance of this group is the disease known as Hodgkin's disease, or lymphadenoma. Hodgkin's disease, as I daresay you know, is a disease the characters of which are enlargement of the lymphatic glands, a deposit of gland tissue growth in the spleen, a moderate or greater enlargement of the spleen itself, and anæmia. There may be, in addition, a growth of lymph gland tissue in other parts, such as the liver and kidneys and heart, and sometimes under the serous membranes. This disease is occasionally accompanied by fever, and you may say, if all these enlargements are present, there cannot be very much difficulty in coming to a conclusion as to the nature of the disease. But experience shows that the enlargements of the glands are not always present in the early stages, or that the changes may at first only affect the deeper glands, which are not readily accessible to observation.

Moreover, the splenic enlargement may be comparatively slight, and even if it is decided, it may not be distinctive, since the spleen is enlarged in some of the other complaints which I have mentioned.

In the first described cases of Hodgkin's disease—and some of the earliest after Hodgkin were those by Sir Samuel Wilks—little was said about the accompanying fever; clinical thermometers were not then in general use. Trousseau (1865) says that the disease disturbs digestion, and causes profuse sweats and hectic fever. Sir William Gowers, in a paper published in 1879, described the high temperature occurring in the disease, and said it might be a continuous high temperature; a high or a series of pyrexial periods alternating with apyrexial periods; or thirdly, an oscillating temperature with morning remissions and evening exacerbations.

What I want to call your attention to, is, not the cases which are recognised as Hodgkin's disease at once by obvious glandular enlargement, in the absence of leucocytosis, but to those in which a difficulty arises because there is a high temperature without sufficiently convincing evidence of the exact nature of the disease.

I had a case which was of considerable interest in this relation six years ago, and there can be no doubt that it was an illustration of this factor in Hodgkin's disease. He was a patient who had suffered three or four years previously from obscure pain in the back, which it was difficult to explain. He recovered from that, and some months afterwards he had enlarged glands on the left side of his neck, which disappeared, but were succeeded by enlargements of glands in the other side of the neck and in the groin; they were of no great size, and more than once disappeared. More than two years after his first symptoms he became febrile, and for a period of at least twelve months, during which time his temperature was diligently taken, it oscillated with remarkable regularity, from 98° or 99° in the morning to 101° or 102° in the evening, though there were occasional periods of seven to ten days length, during which the temperature was normal. But the febrile periods far exceeded the unfebrile. During that time I saw him frequently, and examined him carefully. It was soon clear that he was not suffering from typhoid fever. Tuberculosis was examined for, but there was no sign of that disease in any part of his lungs. In the early period of the febrile illness he was found to have an enlarged spleen, and some glands in the neck and groin were enlarged; but they were never very big, and some subsided after a few weeks. The liver and abdomen seemed healthy, and there was no alteration of his blood. He was not very anæmic. There was at one time a small subcutaneous lump under the tissue over the scapula, which may have been a lymphatic gland, though it is not a common place to find one; and this also diminished after a time.

During the greater part of these twelve months he could get about freely. He gave up his business, but he took riding exercise in a quiet way. However, in spite of remedies, he got eventually weaker, and then he developed more definite signs showing the implication of the blood; that is to say, he had hæmorrhage from the kidneys, and then pleurisy with effusion; and the spleen and liver were both enlarged. He was tapped, but got further hæmorrhages, and ultimately he died. There was no *post-mortem* examination, but I think if you take the whole history into consideration—the enlarged spleen, the transitory swellings, one of which at least was glandular, the persistent fever, and the final termination by means of hæmorrhages and serous inflammations, you will admit that the case was more likely to be Hodgkin's disease than anything else.

This, if it be accepted as Hodgkin's disease, presented an instance of the continuous hectic form of temperature. The remittent or recurrent form of pyrexia is also of very great interest.

In 1887 Ebstein reported a case of illness in which the patient had fever, occurring at intervals separated by periods of apyrexia, over 211 days. There were nine paroxysms of fever of an average duration of thirteen to fourteen days, with afebrile intervals of ten to eleven days, making the intervals between the highest temperatures twenty-four days. The patient ultimately died. At the autopsy, white nodules were found in the

pleura and bronchial glands; and the mediastinal lymphatic glands were enlarged, but not softened. There were nodules in the spleen, liver and kidneys. Ebstein recorded the case as one of hard malignant lymphoma, but was unwilling to include it as one of pseudo-leukæmia, which is the German equivalent of Hodgkin's disease. He was not prepared to recognise a fever of this kind in connection with Hodgkin's disease, and in spite of the fact that the other conditions were like those of Hodgkin's disease, the fever precluded him from putting it into that category. Since then other cases have been reported in which a fever of this kind occurred, each attack lasting ten or twelve days, with intervals of seven or eight days; and in many of those the patients have presented lesions which were sufficiently characteristic of Hodgkin's disease. I have here an article by Dr. Musser, of Philadelphia, reprinted from the Transactions of the Association of American Physicians (1901). In it are recorded two cases in which the patients have had a high temperature of this kind, and the lesions have been those of Hodgkin's disease. Owing to Ebstein's description, the condition has been called "Ebstein's disease," or "recurrent fever." That is to say, Ebstein laid stress upon the fever, as the essential part of the disease. The glandular lesions were deep seated, the depositions in the organs were not obvious to him, and, therefore, he only had the fever before him as a definite symptom, but Dr. Musser believes that in future such cases will be shown to be really cases of Hodgkin's disease.

I have quite recently seen a case which tends to confirm this view, the patient having recurrent attacks of fever of four or five days' duration lasting for about five months, with a fatal result. But I am not in a position to give full details at present.

So you have to consider the possibility of prolonged fever, either of this type or of the recurrent type, being due to Hodgkin's disease, whatever Hodgkin's disease may be, whether it be an infection or brought about in some other way; and I ought to say that there are some who believe that it is really a special form of tubercular infection, among whom are Dr. Sternberg and Dr. Musser.

Leukæmia.—It is well known that the different forms of leukæmia or leucocythæmia are frequently accompanied by fever. Of these I will not say much here. The diagnosis would be at once made by an examination of the blood, when the specific form of leucocytosis should be found.

Cancer.—The general impression with regard to cancer is that it does not commonly give rise to fever. But occasionally we meet with cases in which if we do not give credit to the possibility of cancer producing fever we may be wrong.

Dr. Frederick Roberts, in a long article in Allbutt's System of Medicine, dealing with intra-thoracic growths, says, "With regard to pyrexia, it is as a rule practically absent, and indeed in connection with cancerous and sarcomatous growths the temperature is often below normal. During the progress of rapid malignant disease, however, fever is likely to occur, and in the last stages it may be of a hectic type."

Dr. Wilson Fox, in his valuable work on Diseases of the Lungs, also states that fever may accompany the growth of cancer. He says, "Acute general infiltrating cancer may run a course almost indistinguishable from that of acute pneumonia, commencing with rigors, herpetic eruption, high fever, with rapid consolidation of the lung and albuminuria." And again, "In other cases of this class, the disease, with almost identical symptoms, runs an acute course marked by fever, sweating and rapid emaciation, occasionally combined with delirium or coma, and having a deceptive resemblance to tubercular meningitis." One has, therefore, to recognise cancer as contributing to the production of a prolonged fever.

Here again it must be admitted that in most cases of this kind there is a local lesion, to which attention has been directed at the time the pyrexia appeared; so that the diagnostic difficulty is less often concerned with an apparently causeless pyrexia, than with a pyrexia having an obvious local lesion, which is open itself to two or three interpretations.

As I showed in my first lecture that pyrexial broncho-pneumonia might be confounded with pyrexial tuberculosis, so here pyrexial cancer may be confounded with pyrexial pneumonia, or pyrexial pleurisy.

Cirrhosis of the liver.—The late Dr. Carrington, an Assistant Physician to Guy's Hospital, was largely instrumental in calling the attention of the profession to the fact that cirrhosis might be accompanied by fever, and he published cases in Guy's Reports many years ago showing this connection. It does not always occur, and I do not know that it has been shown what it is in these cases which gives rise to the fever. Its importance is of the same kind as that of the fever in cancer. You are not very likely to have a high temperature due to cirrhosis of the liver without any evidence of the cirrhosis. But you may remember that the ascites of cirrhosis may readily be confounded with the ascites of tubercular peritonitis. And it is important to recognise that a high temperature accompanying the changes in the abdomen is not conclusive evidence that tubercular peritonitis is the cause.

Neurotic cases.—I shall now speak of some cases which are called neurotic cases. From time to time, and especially in females, one sees a case of more or less prolonged pyrexia extending over three or four weeks, without the physician being able to find any satisfactory cause for its occurrence, either at the time or afterwards. As one may suppose, such cases are more likely to occur in those people who are characteristically neurotic, whose nervous system is likely to be upset, and especially in emotional and excitable females. The cause may lie in some emotional condition, or family trouble. I remember a case some years ago which was seen by one of my colleagues and myself, the patient being a lady who had a high temperature of this kind. It was quite irregular, up one day and lower another day; it seemed to present no regularity or type which would make it conform at all to either typhoid or phthisis, or any other of the well known diseases, and the patient got perfectly well, and remains so, to the best of my belief, now. Another instance, in which one was very much inclined to refer the disease to a neurotic condition, though perhaps with less certainty, was that of a lady who was very anæmic after a confinement. The confinement had been perfectly satisfactory. Soon afterwards the temperature rose, and it continued to have a hectic character for two or three weeks, during which time the patient had no other symptom except the marked anæmia. After very careful examinations, which were made for the purpose of finding any septic source, it was definitely determined by an obstetric consultant that there was nothing locally the matter. Almost immediately, and without any other clinical change, the temperature subsided and the patient got well.

Undiagnosed cases.—With improved methods of observation and greater experience from post-mortem investigations, one would think that it ought to be possible for us to come to a reasonable diagnosis in any cases of prolonged pyrexia. It has, however, been for a long time recognised that cases occur, and perhaps more frequently in children, in which there is fever of a not very severe type, which lasts several weeks and ends in recovery, without yielding any sufficient evidences to reveal its origin. We may hope that such cases will become less and less, for the sake of our professional credit, though, as I have intimated, it is generally the fact of recovery that is at once an indication of the mildness of the process, and a happy limit to the prosecution of our researches.

I remember at the Evelina Hospital for Sick Children the case of a boy aged six or seven years who had prolonged pyrexia, with a temperature rising in the evening and falling in the morning. We kept watch for evidences of tubercle and typhoid fever and other ailments. After the patient had been ill for six weeks, the Evelina Hospital was emptied of patients for its periodical cleaning, and the child came into this hospital. For five or six weeks he was ill with the same continued fever; so that three months was the minimum duration of his illness. Then he gradually got better, without any sign whatever having developed which could be said to point to a local lesion, or any evidence of the particular nature of the complaint. Two or

three years afterwards he was in perfect health, and had had no recurrence of his symptoms.

The probability is that such cases are tubercular, or mild forms of typhoid fever, or septic processes dependent on a remote localised septic focus.

Leucocytosis.—I have left it to the last to refer to a special method of clinical investigation, by which some distinction can be drawn between one febrile process and another. I mean counting the blood corpuscles, and especially the white cells or leucocytes.

The leucocytosis, under these circumstances, shows an increase in nearly the normal proportion of the leucocytes which are found in healthy blood; and differs from leucocythæmia or leukæmia, in which one or other form of leucocyte is immensely in excess, and especially from that form called myelœmia in which myelocytes or marrow cells are present in great numbers. Leucocytosis besides occurring after digestion, is found in many acute inflammations, in the course of suppuration, septicæmia, pyæmia, erysipelas, cerebro-spinal fevers, pneumonia, pleurisy, empyema, phthisis, scarlet fever, and rheumatic fever.

We can scarcely hope, then, that all these can be distinguished from one another by this method. But there is little or no increase of leucocytes in typhoid fever, in malaria, and in miliary tuberculosis; and under suitable circumstances the presence or absence of one of these may be determined as against some member of the other group. No doubt a good deal of work has yet to be done upon this subject, and it is impossible for me to do more than refer to it at the present time; and advise you to become familiar with the method of blood counting, and to make the investigations in cases where there is much doubt.

Papers by Guy's Men.

Examination of the Blood: with Examples of the Wide Range of its Value. By Herbert French, B.M. Oxon., M.R.C.P. Lond.—*Practitioner*, March, 1903.

On the Mode of Production of Fractures of the Lower Extremity by Indirect Violence (Illustrated). By W. Arbuthnot Lane, M.S.—*Ibid.*

Re-opening of Job.

The quiet ceremony that signalized the re-opening of Job by Mrs. Farquhar, in memory of her husband, took the form of a tea in the ward on Friday, March 20th. No attempt was made to render it a "function," but after the reception given by Mrs. Farquhar, the generosity of Mrs. Farquhar and her son was recognised in the short and dignified speeches that the Surgeon to the Ward and the Treasurer made, and the memorial nature of the gift was brought to the front in the singularly moving reply in which Mrs. Farquhar referred to the origin of the gift.

After the visitors, for there were no invitations issued, had admired the gloss, the colouring, and the modern and model arrangements and out-houses that have been erected, and had made a tour of the patients, they assembled in front of Job fireplace to hear Mr. Charters Symonds invite Mrs. Farquhar, in the name of the Staff, to declare the Ward open, and to thank her for the gift.

Mr. Symonds said he considered it a great privilege to offer to Mrs. Farquhar and her son the thanks of all concerned in the welfare of the hospital, for the generous gift they had made. The selection of teak, a wood of known durability, for the floor, seemed to him to typify the lasting nature of the memorial. Nothing that could add to the beauty, usefulness and brightness of the ward seemed to have been forgotten. The memorial plaque over the fireplace was itself a work of art, and was again in keeping with the design of the donors. In spending so much upon the reconstruction of the Ward, Mrs. Farquhar thereby testified to her belief in the permanency of the great institution in which we were all so deeply interested. In the name of the Staff and the Sisters and Nurses, Mr. Symonds tendered to Mrs. Farquhar and her son their deep appreciation of the many comforts they had provided, and assured them that for so long as the ward existed, the memory they trusted to perpetuate would not be forgotten. In conclusion, he begged Mrs. Farquhar to declare the ward open.

Mr. Cosmo Bonsor (Treasurer) said that everyone, whether governors, members of the surgical staff or nursing staff, thanked Mrs. Farquhar and her son for making the renovation of the ward possible. Mr. Symonds had alluded to the floor,—he wished to say a word about the ceiling. The ceiling was a new departure, and the first ever put up that was absolutely fire-proof. Uralite was a mixture of asbestos and chalk; it was sent over in slabs from Russia, ready for putting up. It was covered with a coating of paint, and the entire ceiling was extremely well-adapted for a modern scientific hospital ward. Mr. Bonsor added that the late Mr. W. Farquhar had been one of his own oldest friends; he was taken away at a time when he could least be spared, and it was a great relief to think that his memory would be perpetuated in this way. He could assure Mrs. Farquhar and her son that the governors were extremely grateful to her; after all, Guy's was not a thing of yesterday or

to-day; it was an institution that had already borne its share in the welfare of mankind, and it was destined to endure, and no better place for a lasting memorial of that kind could be found.

Mrs. Farquhar, speaking with evident emotion, thanked Mr. Bonsor and Mr. Symonds in a short reply of much feeling, which was attentively followed in silence by the assembly. It brought to mind the old and expressive sentence—

Sunt lacrymæ rerum, et mentem mortalia tangunt.

Case for Diagnosis.

E. B., multipara, age 36, was admitted on March 9th, 1903, into "Victoria," under Dr. Horrocks.

Patient complains of:—(1) Sudden attack of pain in the abdomen, together with labour pains, when three months pregnant; (2) sudden increase in size of the abdomen, and continuous pain in this region during the past month.

History of present trouble.—The last child is now a year and a half old. Menstruation reappeared after this pregnancy on June 21st, 1902, and was quite normal for four months. The last menstruation was on October 21st, lasting until October 28th, 1902. Patient was quite well during the latter part of the year 1902, and remembers no occasion on which she injured herself in any way, or noticing any vaginal discharge. On January 31st this year, before getting up one morning, she was seized with acute abdominal pain, during which she fainted; and shortly after this, "labour" pains came on. A doctor was called in. There was no discharge at all noticed from the vagina at this time, nor has any been noted since. Patient was treated with medicine, and ordered to lie up in bed for a week. She then got up, but the pain came on so severely, that she was obliged to go back to bed. She first noticed at this time, that the abdomen was very distended, and says that it was about the size she would expect to see it at full term. Since that time she thinks that it has got somewhat larger. Patient has remained in bed since then (February 6th), the pain continuing,—worse at some times than others. A fortnight ago she had an attack of diarrhœa lasting a few days, otherwise the functions of bladder and rectum have been normally carried out. Last Friday, March 6th, the pain came on very badly, accompanied by severe pain in the limbs. For a few days the temperature varied between 100° and 105° F. The joint pains abated, though abdominal pain, especially in the left side continued. Dr. Horrocks, who was called in for consultation, advised patient's removal to Guy's.

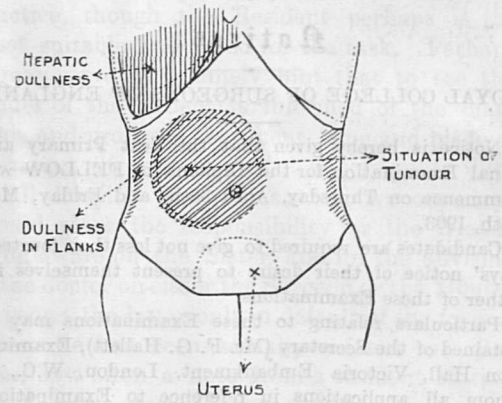
On admission.—Pulse 100, temperature 98·4°, respiration 20. During the last two days patient says the pain seems to have shifted rather more into the back passage, continuing also in the left side of the pelvis.

Further history.—Patient has had seven full time children. The eldest is now fifteen years old (she has been married sixteen years). The youngest is eighteen months old. The others were born at regular intervals. She has had no miscarriages. The labours were normal. No instruments were used. Lactation was also normal in each case. All the children are alive and well.

Menstruation began at the age of sixteen. Up to the time of her first pregnancy she was quite regular, going four weeks, and losing a moderate amount. No dysmenorrhœa. Between the subsequent pregnancies she has also been quite regular, losing a moderate amount. No dysmenorrhœa.

General condition.—Has always been, up to the time the present trouble began, an exceedingly healthy woman. During the past seven weeks, however, she says she has wasted very rapidly. Her appetite has been poor, and she seems to have been living upon fluids and a farinaceous diet all this time. She has had no morning sickness since the end of January, and has up to the present felt no movements. The breasts, which were then fairly full, are now quite empty, though still deeply pigmented. She looks ill; marked wasting in temporal fossæ and face. Circulatory system—a faint localised systolic bruit at the apex; otherwise normal. Urine—acid in reaction; gravity 1025; a large deposit of urates; no albumen or sugar present. Other systems normal.

On abdominal examination.—The abdomen is distended, the distension being more to the right side than the left, though on the whole globular, and most marked at the level of the umbilicus. On palpation; a tumour can be felt occupying the abdomen, situated chiefly to the right of, and above the umbilicus, but extending a short distance below and to the left as well. The surface of it is smooth. The flanks are dull, and a marked thrill can



be obtained. The tumour is hard, and somewhat tender on palpation, and is distinct from the hepatic dulness in the flanks. The liver cannot be felt. The uterus can be felt distinct from the tumour, about three and a half inches above the pelvis, and about one and a half inches below the lower border of the tumour described above.

On vaginal examination.—The os is fairly high up, patulous, admitting the finger. Douglas' pouch is apparently empty. Pregnancy was diagnosed.

(For Solution see p. 140.)

Appointments.

CIVIL.

Spriggs, Edmund Ivens, M.D. Lond., M.R.C.P., has been appointed Physician to the Out-Patient Department in the City of London Hospital for Diseases of the Chest.

Stamford, R. B., F.R.C.S. Edin., L.R.C.P. Lond., M.R.C.S., has been appointed Honorary Medical Officer to the Loughborough and District Hospital and Dispensary.

Telling, Walter H. Maxwell, M.D., B.S. Lond., M.R.C.P., has been appointed Honorary Physician to Leeds Public Dispensary, *vice* C. L. Chadwick, M.A., M.D., F.R.C.P., resigned.

NAVAL AND MILITARY.

Surgeon Stanley S. H. Shannon, R.N., has been appointed to the *Impregnable* for the *Nautilus*.

Surgeon-Lieutenant-Colonel F. Smith, V.D., 2nd Kent Royal Garrison Artillery (Volunteers), resigns his Commission, with permission to retain his rank, and to wear the uniform of the corps on retirement.

Surgeon-Captain C. S. Ticehurst, 3rd (Duke of Connaught's Own) Volunteer Battalion the Hampshire Regiment, resigns his Commission, and is granted the honorary rank of Surgeon-Major, retaining his uniform.

Mr. G. Warwick Smith, M.B., and Mr. H. Vale Bagshawe, have been gazetted Lieutenants in the Royal Army Medical Corps.

Notices.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

Notice is hereby given that the next Primary and Final Examination for the Diploma of FELLOW will commence on Thursday, April 30th, and Friday, May 15th, 1903.

Candidates are required to give not less than fourteen days' notice of their desire to present themselves for either of these Examinations.

Particulars relating to these Examinations may be obtained of the Secretary (Mr. F. G. Hallett), Examination Hall, Victoria Embankment, London, W.C., to whom all applications in reference to Examinations should be addressed.

The required Fees must be paid three days prior to the Examinations.

March 11th, 1903.

LICENCE IN DENTAL SURGERY.

Old Regulations.

Notice is hereby given that the next Examination will commence on Friday, May 1st, 1903.

New Regulations.

Notice is hereby given that the First and Second Professional Examinations will commence on Friday, May 1st, 1903.

Candidates are required to give not less than twenty-one clear days' notice in writing of their desire to present themselves for either of these Examinations to the Secretary (Mr. F. G. Hallett), Examination Hall, Victoria Embankment, W.C., from whom all particulars relating thereto may be obtained.

March 11th, 1903.

Medical Department of the Navy,
Admiralty, S.W.
1st March, 1903.

An Examination of Candidates for entry into the Medical Department of the Royal Navy will be held on the 11th May next and following days at Examination Hall, Thames Embankment.

The forms to be filled up by Candidates will be supplied on application to this Department.

H. F. NORBURY, Director-General.

From the Gazette's Special Pathologist.

All specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. Wells.

NOTICE.

R. D. A., Hertford.—This is a good example of advanced cirrhosis of the liver in a child, but the etiology of the condition is very obscure. There is a great excess of the fibrous stroma between the lobules, and the biliary ducts in this new fibrous tissue are abundant. The enclosed hepatic lobules also show much fatty degeneration of their cells, especially in the central areas. Is there any possibility of chronic alcoholism?

H. A. C., Saxmundham.—The specimen was non-purulent in character, and no tubercle bacilli were detected in it.

PATHOLOGIST.

Passim.

The end of the long Winter Session has come, and the greatly altered Park will soon assume its spring appearance. Job is reinstalled, and there is great activity in old Mary, shortly to become Stephen. The Wills' Library looks magnificent, and the oak is splendid, massive, and altogether delightful.

The alterations of the last few years in the names of the wards, appeal more to the past than the present. Already the name of Accident has fallen into oblivion, and Addison ward would puzzle the ward clerk. It is to be hoped that the name of Addison will not be lost sight of. Why not Addison instead of Philip, who was but an uninteresting saint, and who now must perforce sever his connection with his former local habitation?

The Residents acknowledge with many thanks the donations to the Christmas theatricals from the Treasurer, the Matron, Mr. Targett, Dr. Shaw, Dr. Pitt, Dr. Fawcett, Mr. Newland-Pedley, Dr. Rix, Mr. Sichel and Dr. Vaughan Pendred; a Bright patient contributed twenty-two shillings, and Anon was responsible for one pound. The cost was twenty-two pounds. The Residents feel their deep indebtedness to those who enabled them to give the Nursing Staff an entertainment which we believe they most thoroughly enjoyed and deserved.

At the same time they are anxious to let it be known that the sportsman who wrote just before Christmas:—"Carry the Christmas Festivities through exactly on the lines of previous years, and can send me a memo. of the amount you find yourself to the bad. There is only one condition, my name in the matter must not leak out." This generous offer was gratefully accepted, but circumstances luckily allowed us eventually not to have resource to it; in other words, ends were made to meet without abating previous efforts. They are also indebted to one of the senior surgeons, who similarly enquired if there was a deficit, and expressed his willingness to help. We can only say that we have here only another proof of the readiness of the Staff and others to assist in every way what they recognise to be good work.

A letter to the *St. Mary's Gazette* raises a question about which there can be no two opinions in theory, though, whether the practice is all one could desire is not so obvious. It is the plaint, temperately enough worded, of the general practitioner that he got no information about his case till it was in a dangerous condition, and he pleads for more consideration. In our own case the close and mutual consideration that ought to, and usually does, prevail in the matter of cases is all that we can desire, but exactly how the information is conveyed varies considerably. Some surgeons invariably inform the doctors themselves by a post-card, others tell the patient or his house-surgeon to write, and both the methods are unexceptional and both present obvious advantages. Others ask the Sister, and others the Resident, and some leave it to chance, which, however, but rarely fails them.

The latter three alternatives are not good practice, though the Resident perhaps is the most suitable and fitted for the task. Perhaps it may serve as a timely hint that to see the sender of the patient is informed of the diagnosis and proposed treatment, time and place of operation (if any) is the obviously polite duty of all hospital authorities; and we ourselves should place the responsibility for the friends being aware on the Sister, and for the advising of the doctor on either the Surgeon or the House-surgeon; the latter only in default of the former unless he has been actually written to. But then, how often a note from a resident stating the hospital view of the case is taken quite unfairly as an attempt to teach, and resented accordingly!!

There are a number of our Students who graduated at the London University in 1901 or 1902, and will therefore be described as "External Students" on their Diplomas, unless they wish to take advantage of the following resolution

passed by the Senate. It is as follows :—"That Students who graduated in 1901 or 1902, and who can submit certificates from a School or Schools of the University, or from recognised Teachers, to the effect that they have completed a full course of study for the Intermediate and Final Examination, extending in all over not less than two years, be granted Diplomas worded as those issued before the reconstitution of the University, and without reference to the distinction between Internal and External Students." The Dean will be glad if any Graduate who wishes for such a certificate, will send in his name at once to him.

NEUTRAL DIPLOMAS. — The following letter indicates the necessity for decision without delay :—

> Dear Sir,—I am directed by the Academic Registrar to state that all Students who may wish to exchange their External Diplomas for the above, must return the External Diploma already issued before April 7th, 1903, after which date no Diplomas can be accepted for exchange.—Yours, ————

THE season has ended with an unparalleled and notable achievement. For the first time on record in the history of the Rugby, Soccer and Junior Soccer, these Challenge Cups are housed together in our Smoking Room. In 1886 we held the first two—the year of the institution of the "Soccer" Cup, in 1892 St. Thomas's held them both, and now we hold all three, a feat only possible the last six years. Pride, alas, goeth before a fall, but we would endeavour to placate the gods by humility. We cannot but point out that we have won the Rugger Cup nine times to St. Thomas's ten; the Soccer Cup seven times to St. Bart.'s five, and the Junior three times out of six. It speaks well of the devotion of our men to sport and of all-round excellence and energy.

QUITE an old friend returned to us when the Cross County Cup found a resting place in the Guy's Smoking Room this year. It is with no spirit of detraction that we say it came of its own accord because there was no opposition, but we congratulate Mr. O. Norton most heartily on the excellent work he has done on behalf of the United Hospitals Hare and Hounds, and feel that his success has been most deserved.

As we were going to press for the last number news reached us that we had won the Soccer Cup, and we were gratified and proud. The Residents, with commendable energy, arranged to dine the victorious XI. as their guests and a most enjoyable evening was the result. Soccer has been on the decline in London as a pastime for gentlemen, and truly amateur clubs are few and far between. An example of this may be gained from the fact that a foul and a penalty kick settled one round this year, and that this is by no means uncommon and excites no special comment. It is an example of the degraded state of a once most sportsmanlike game, and of the utter ruin that has followed the introduction of the paid player into any sports, with the possible exception of cricket, where his sphere of activity is limited and not obnoxious. We fear that amateur "Soccer" has no future before it.

THE *St. Thomas's Hospital Gazette* contains many amusing pieces, but none of more interest to us than the account of their game with us. It so exactly expressed what happened that it is worth quoting :—

> "A game not characterised by that rough play and fighting that is so often the feature of an inter-hospital cup-tie, but a sound example of what Rugby football should be—a match between sterling good forwards on the one side and an unusually brilliant lot of 'outsides' on the other . . . . that it was an honourable defeat after a most even and plucky fight, in which we had as much of the game as our opponents, and that the team one and all covered themselves with glory, none deny, least of all our sportmanlike opponents, who for their victory had to fight to the bitter end as hard as we did."

Such a genial description from our ancient foe is well in keeping with the cheers they gave us when we at length wrested the Cup from them in 1898, and with the wish they then expressed that if they could not keep it that Guy's might get it, and we can only add that they were certainly at once the most powerful and sporting opponents we met this year.

Correspondence.

To the Editor of Guy's Hospital Gazette.

The Medical Man and the Coroner.

Dear Sir,—While sympathising with the doctors in the way in which they are apparently being excluded from inquests, I cannot help supporting the coroner in his attempt to make post-mortem examinations the work of a specialist.

In the last number of the Gazette you say that when the ordinary conjoint man cannot find a cause of death after a careful post-mortem it will be rare for a specialist to enlighten him. Can that really be your experience of conjoint men or of post-mortems?

There is no subject in the whole field of medicine in which there are greater difficulties or in which expert knowledge is more necessary than in morbid anatomy. A constant attendance in the post-mortem room will soon show anyone the truth of that, and if he is then confident in his own powers let him demonstrate a few autopsies to half a dozen senior students, and he must be an exceptionally good man if he does not find himself in difficulties. Of course there are cases in which any qualified man is competent to give an opinion. But it is in cases where death has been sudden, and where the morbid process has only been of short duration that inquests are necessary, and it is in just such cases that the post-mortem appearances are so deceptive.

Take the early stages of pneumonia; the kidneys, which are neither typically granular nor large and pale, and yet to the expert are sufficiently diseased to account for uræmia. Have you not seen examples of these changes passed from student to student without the true condition being detected? How many brains are called "congested" simply because the vessels are found full of blood? How many men have called the fibrous nodules he meets with in the pleura, tubercles? I have. How many ordinary men know the difference between a fatty heart and a heart with a good deal of fat on it? Men who make all these mistakes within a few weeks of qualifying are not likely to know much more pathology after ten or fifteen years of general practice, in which they probably don't see six autopsies. I could quote instances recently come before me where obvious lesions, and lesions which caused death, were not properly appreciated by men who are by no means fools, while in a paper I heard read the other day by a man in a large good class practice, some statements were made which strained my pathological credulity to the breaking point.

I hope that no one will suspect that I am trying under a thin disguise to exalt the man with the degree against the worthy M.R.C.S. I have used the term Conjoint man because you did so, but we both probably mean by that expression the average general practitioner whether he hails from Blackfriars, Edinburgh or London.

Any point is that post-mortem work is a specialty, and we should no more expect middle-aged general practitioners to be conversant with the intricacies of morbid anatomy, than we should insist on the Superintendents of Asylums knowing the proper treatment for a prolapsed funis presentation, or the diagnostic signs of a para-tubal hæmatocele (whatever that may be). Neither is it desirable that men in busy practice, attending perhaps two confinements a week should be called upon to handle decomposing viscera in between their visits.

The rational solution of the difficulty seems to be that a post-mortem examination should be done by the expert, that the G. P. should be notified of the fact, and could attend if he liked, while both should be present at the inquest. The increase in the cost would not be considerable, and in these days expense is no object to the powers that be. There is one other way, which is followed with great success in the provincial district from which this letter comes. Never call a medical man at all. The daughter, or grandmother, or maid of all work is quite competent to give an opinion as to whether death was natural or not, and the Coroner and jury are saved the bother of trying to understand medical terms, while the doctor need not defend his treatment of whooping cough from the criticism of a jurior whose infant was cured of the "inwardly fits" by a herbalist.

I am, etc.,

"COMPETENT PATHOLOGIST."

Nephrotomy, &c., and the Physical Society.

Sir,—I observe that Mr. Golding-Bird made some very kind remarks in reference to myself at the recent Dental Society's Dinner, the report of which in your last issue represents him to have said "especially mentioned Larkin, who in 1859 wrote a paper on nephrectomy, etc.—It should have been 1869.

It may interest some of your readers to know how that paper came to be written.

One day a man was brought in, having been knocked down in the Borough by a cab, the shaft of which hit him violently in the back. He soon was passing blood in his urine, and rapidly became comatose and died. At the post-mortem we found that the fatal blow had injured his only working kidney—the other had atrophied away.

Just about that time I was much interested in the case of a patient under the care of the late Dr. Habershon, who was suffering frightful pain from renal calculus.

These two cases set me thinking a great deal, and I decided to make a series of experiments on rabbits. At this time let me remind you there was no vivisection bill; but, for all that, every operation I performed was done under chloroform, and always successfully. To be brief, the result was a paper in 1869, in which was discussed the arguments of the present day renal surgery in all its bearings, and which I may describe as up-to-date, minus, of course, antisepsis, notwithstanding which, as I said

before, all my "cases" did well; and many were exhibited at that meeting of the Physical Society; each rabbit working with one kidney, whilst its respective fellow, which I had removed months before, was on the table; all the specimens, by-the-bye, having been most kindly put up for me by our dear old friend Betts. The specimens afterwards went to the museum. It was interesting to observe the very marked hypertrophy of the organ, which for several months had been doing double duty.

The late Mr. Edward Cock, as President of the Society, was in the Chair, as it was the first night of the session; and Dr. Pye-Smith together with the late Dr. J. J. Phillips (who subsequently became Assistant Obstetric Physician), were the Honorary Secretaries, whilst included in the list of Vice-Presidents were a few of the Senior Members of the present Hospital Staff.

I was always a very regular attendant at the Physical Society and have made it a rule to try and be at the first and last meetings ever since I left the Hospital. I cannot lay too much stress on the importance and duty of every student supporting the Society by his presence. In many ways it benefits the man who does so. For one thing, it brings about the habit of public speaking, which in after-life is sure to be required of him at times, and on unexpected occasions too.

Many years ago I remember being invited to attend a discussion on Renal Surgery at the Medico-Chirurgical Society, and in my remarks I did not forget to mention, and was, I hope, pardonably proud to claim some at least of the early association of Renal Surgery with the Guy's Hospital Pupils' Physical Society.—I am, sir, yours truly,

F. G. LARKIN.

March 9th, 1903.

Indecision and in Doubt.

Dear Sir,—May I be permitted through the columns of the Gazette to suggest that the post-mortem demonstrators should hold their almost daily meetings at 12.30 p.m., instead of 2 p.m. In the first place the parts would be ready for the physicians' inspection when they arrived; and secondly, and perhaps of almost equal importance, men in the same position as myself, would not have to decide the sometime weighty question whether to see the inspection, or whether to patronize the Out-patient department, etc., but would be able to do both. At the same time may I call attention to the enormous accumulation of dust on some of the museum specimens, here and there finger marks occasionally relieving the monotony.

Hoping I have not trespassed too much on your valuable space.—Yours truly,

A. C. H. RONIC.

[A good but we fear unpracticable suggestion.—Ed.]

A Point in Medical Ethics.

Newington Workhouse.

Dear Sir,—Young consultants occasionally having some qualms in accepting a fee, I venture to enclose for their guidance a sketch list of the various classes of people who expect to be advised without payment of a fee and who may be somewhat surprised and offended at the mention of any pecuniary omission.—Yours sincerely,

"A RETIRED CONSULTANT."

Doctors.
- Doctors' wives.
- " children.
- " relatives to the third generation
- " widows.
- " orphans.
- " friends.

Ladies, whose children, as doctors, have died young.

Students.
- Students' parents.
- " relatives.
- " fiancées.
- " eventual wives.

Nurses.
- Nurses' parents.
- " brothers.
- " sisters.
- " aunts.
- " uncles.
- " cousins of the maternal side.
- " " paternal side.
- " other near relatives.
- " distant relatives.

Clergymen.
- Clergymen's wives.
- " parents.
- " children (the first two only; subsequent additions to the family, half this fee.
- " relatives.
- " worthy parishioners.
- " occasional converts.
- " orphans.

Church workers.
Missioners.
District visitors.
- " relatives.

Plymouth Brethren.
Peculiar People.
Shakers.
Mormon's female relatives.
Deserving Jews (occasional)
Dentists.
- Dentists, relatives.
- Dental mechanicians.
- Dental students.
- " lady friends.

Actors.
Actresses.
Actor managers.
Actor baronets and knights
Authors.
Impresarios.
Opera singers.
Scene shifters.
The corps de ballet.
Musicians.
Violinists.
Composers.
Ballad writers.
The Peerage.
Servants of the Peerage.
Servants of all classes of society.
Nuns.
Sisters of Mercy.
Little Sisters of the Poor.
Begging Friars.
Importunate widows.
Typewriters.
Racing men.
Undertakers.
Sextons.
Grave diggers.
Insurance Agents.
Old friends of your mother's.
Old friends of your father's.
Your old schoolmaster.
His family and friends.
Old schoolfellows.
Their family and friends.
People who owe you money.
People to whom you owe money.
Chiropodists and conjurers
Mesmerists and masseuses.
Pawnbrokers.
Millionaires in reduced circumstances.
The Army.
The Navy.
The Reserve Forces.
The Police.
People of extreme youth or advanced old age.
Pretty girls.
etc. etc.

Guy's Hospital Debating Society.

"The opposer rose with eyeballs tense,
And swollen frontal veins;
To all his powers of eloquence
He gave the fullest reins."—GILBERT.

On the evening of Saturday, February 28th, the Smoking Room was once again the scene of heated debate. Mr. Ormond took the chair at 8.15, and the minutes of the previous meeting having been read and confirmed, futile attempts were made on the part of two of the most self-sufficient of the Chronics to disturb the serene equanimity of the Junior Secretary by their pseudo-business questions.

Mr. RALPH THOMPSON (who, by the way, was looking extremely well) unsuspectingly asked for enlightenment as to the name and nature of the implement which decorated the left-hand side of the chairman's table. On being told, gently but firmly, that it was a coke-hammer, he sat down, suppressing a strong shudder.

A convulsive movement was next seen amongst the dilettanti occupiers of the cross benches. Viewed from afar it strongly resembled œsophageal peristalsis. Its result was the sudden appearance of Mr. PERCY BOLUS, clothed in red waistcoat, mystic, wonderful, and be-spangled with brazen buttons. This resplendent being took great exception to the gentlemanly prefix which had on several occasions appeared before his name in the annals of the Society. He was, he declared, a physiologist and not a gentleman, and he begged that in the future his surname alone might appear in the classic pages of the minute book. There were also the weightier considerations of his anthropomorphic appearance which rendered incongruous any appellations other than those of the extremest antiquity (such as "the old thing").

He was told in the most tactful manner that obscurity of diction and idea were two deadly sins, peculiarly attractive, no doubt, to a physiologist, but none the less unpardonable in a cultured assembly; whereupon the cross benches *swallowed* him once again, and this time successfully.

Mr. STANLEY HODGSON, a gentleman whose appearance deceptively suggests the extremest acumen, next arose and pertinently enquired as to the occupation and whereabouts of Mr. ERNEST HARRISON GRIFFIN, the Senior Secretary. He was told that that gentleman was engaged in certain time-honoured duties in Leicester and its environs. (Loud and persistent coughing from the externs.)

The JUNIOR SECRETARY now addressed the House in a mellifluous manner. He spoke of the approaching Ladies' Night with a persuasion and a gallantry that at once raised the whole tone of the proceedings. Having dealt delicately with the charms of femininity which were "as old as Eden—ambient as the air," he went on to speak of the transcendental flights of oratory which it was possible to achieve in the presence of one's "cousins," and when he sat down, which he did all too soon, he was greeted by a burst of rapturous applause, which augured well for the success of the festival he announced.

It now fell to the lot of the previously-mentioned Mr. STANLEY HODGSON to demonstrate to an enchanted House that Napoleon, in spite of all appearances to the contrary, was a heaven-sent being, who had brought many blessings to mankind. Long enough had the world stoned this prophet of the race; it was now high time that his sepulchre should be built, and by the kindly aid of heaven, and the House, he would that evening lay the first stone of a worthy and everlasting memorial. (Loud cheers, in which the speaker also joined.) Forthwith, in wreaths and festoons of exotic argument, there was woven a quaint conceit. Transcendent genius was the excuse put forward for some of the grosser flaws of Napoleon's character. His immorality, being negative, partook of the nature of virtue, and the energy which he awakened in France, reacting upon Europe, aroused ideals which had long been lying dormant. He would say, without hesitation, that it was to the influence of Napoleon we owed the inception of "the Imperial Idea." At this point, as was natural in a well-fed and healthy British audience, the speaker's voice was drowned in a roar of applause. Amid the thunders of patriotism Mr. Hodgson could be heard referring to "Fashoda"—"those characteristics which make us Englishmen what we *are*"—"little Englandism the menace of the honourable opposer"—"the final supremacy of the Anglo-Saxon race!" Having perorated in this strain for two or three pregnant minutes, Mr. Stanley Hodgson resumed his seat, trembling with emotion, and menacing eyes were turned in the direction of the honourable opposer, who, as we have already mentioned, was looking extremely well. Had Mr. RALPH THOMPSON flinched beneath that fire of eyes, had he done what many a smaller soul would have done, had he run from the room, and from the building,—then the triumph of Mr. Stanley Hodgson would have been complete, and this chronicle would have come to an untimely end. The honourable opposer, however, did none of these things. Perhaps his moustache curled upwards a little less than it had done previous to the outburst of popular fury; but this, if so, was the only sign of his inward struggle for calm. With consummate coolness and with easy grace he rose to his feet, and gave vent to a rhetorical counterblast which will live in the memory of all those who heard it.

Mr. THOMPSON, who seemed from the style and substance of his speech to be on familiar ground, commenced by drawing a comparison between Napoleon and Oliver Cromwell. They were in most respects entirely dissimilar characters, but in their political significance to their respective countries they were very much alike. The point of the analogy lay in the different action of these two men under similar circumstances. Cromwell's death left England in a sound political situation, more honoured in Europe than she had ever been before; while France, on the passing of the Corsican adventurer,

saw all her chimerical dreams of a world-wide empire shattered, and lay helplessly exposed to the vengeance of Europe. The Napoleonist party had been responsible since the death of its founder for much strife and bloodshed, and was for ever fostering that ineradicable tendency of France to the quixotic and melodramic which had made her a byeword among the nations. The great beauty of the speech was the simplicity of its embellishments, nothing more elaborate being used to colour the discourse than simple geographical truths, enunciated in an interesting way.

On the debate being opened to general discussion—

Mr. Percy Bolus once more arose and addressed the House. He spoke of the necessity of taking life seriously. Nothing was more sad than the way in which the young people of to-day trifled away their time on small and often unworthy objects. Napoleon taught us the great lesson of "the serious life." If anybody would like to stay behind and speak to him privately he would be only too pleased to give them advice and comfort. Longfellow's "Psalm of Life" they would find very helpful; it began—"Tell me not in mournful numbers, life is but an——" (swallowed again).

Mr. Herbert Wallace made a few interesting remarks bearing upon Ophthalmic Surgery and its High Priests. (The chairman was seen to smile slightly.)

Mr. Kenneth Black, of Wandsworth, now arose, amid screams of delight, and in the voice and manner of the obscurest of Sunday-school teachers, proceeded to extol the personality and achievements of Napoleon Bounaparte. The childhood of this great man was most sympathetically dealt with, and many French words were pronounced *en passant* with a charm of diction which none but Mr. Kenneth Black can employ. It was at the age of nine months that the little Napoleon made the remark always made by great men in their youth, namely, "I will be great"; and his mother at the time observed that he would in all probability also be fat, a remark which was subsequently justified. Mr. Black said that his infant nickname was "the little corporeal," which was rather quaint, was it not? Napoleon was certainly not a ladies' man, "but he was very fond of children—he was a *devoted* husband." Here Mr. Black burst into tears, and had to be led away.

Mr. Myott, in an interesting speech, endeavoured to prove that Napoleon left Europe, as a whole, more prosperous than he found it.

Mr. Mann next pirouetted into the centre of the floor of the House. He laughed with delightful freshness and insouciance when told that he had grown since the last debate. His step-dance and cake walk caused much amusement and delight. A call for an encore was sternly repressed by the chairman. Incidentally Mr. Mann supported the opposition.

Mr. Brydone, speaking with his accustomed glibness and persuasion, made us almost believe that he meant what he said in support of the proposition. He was wearing a light brown Norfolk jacket which, Mr. Thompson assured us, was not his own.

Mr. Thompson and Mr. Hodgson, having respectively replied, the motion was put to the vote. It ran thus—"That the House considers the personality and achievements of Napoleon Bounaparte to have been beneficial to the world."

For the Motion	29	
Against	22	
Motion carried by a majority of	7	several not voting.

A vote of thanks to the Chairman, Mr. Ormond, closed the evening.

Novelties.

IALINE PREPARATIONS.

We have received from the makers, Messrs. Burt, Boulton & Haywood, the undermentioned disinfectants:—

Ialine "A" Fluid.—This is a dark brown fluid which smells strongly of coal-tar derivatives. With water it forms a milky fluid, and appears to be a mixture of the phenols rendered miscible by means of soap. It does not appear quite so soapy as the fluids of this type.

Ialine Disinfecting Powder.—This is stated to be a 15 per cent. "carbolic powder." It has rather a pleasant clean smell, and should be useful for sprinkling about in urinals, etc.

Carbo-Naphthaline and Naphthaline Tablets.—These have a strong odour of phenols and naphthalene and naphthalene respectively, and are intended, presumably, to be used as a protection against moths and other insects.

No. 1 Miscible Pine Oil Fluid has a pleasant odour of terebene, and with water forms a milky fluid.

Ialine Antiseptic Ointment smells strongly of pyridine, which together with phenol it is stated to contain. It is recommended by the makers for various skin diseases, and has therefore to be stamped with a patent medicine stamp. The basis appears to be soft paraffin. The preparation has not a pleasant odour, but should be useful where a disinfectant application is required.

ASPIRIN.

Aspirin (dose up to 20 grains), which is now in vogue, is used as a substitute for salicylates in similar conditions. In gonorrhœal rheumatism it has been decidedly successful; and in two often unrecognised conditions, gonorrhœal inflammation of the adductor longus fascia, and the better known flat-foot, it has been tried with success.

Perhaps its extended use will add to or confirm the approval it now meets with.

Somewhat Lighter.

A BALLAD OF CADAVERS.

Eighteen men on a dead man's chest,
Ho, ho, ho, and that isn't rum?
Eight and a half got through at the best
Want of Cadavers has done for the rest
Ho for miserly dividendum. [Old Song.]

When students to Cadavers are
As 18 is to one
The dividend's inadequate
The thing cannot be done.

When *two* must share an arm or leg
And *four* take heart and neck
Some forty-three per cent. may pass
The rest will be a "wreck."

At "Owens" and at Birmingham
One man one leg's the rule,
And students have a head apiece
At happy Liverpool.

One guinea there for *three whole parts*
As winter price they fix,
Two more in summer may be had
Dirt cheap at twelve and six.

At Edinburgh (strange but true)
One subject does for *twenty*.
But when the professor's "satisfied"
You get *half* parts in plenty.

But London's best, there merely eight
Divide the parts we prize,
When I want a cadaver, I
Shall go straight off to Guy's.
[Very pleased to see you.—Ed.]
(After the Cambridge Review.)

Papers by Guy's Men.

Some Common Abnormalities of the Child's Skin. By G. Norman Meachen, M.D., B.S., M.R.C.P. Lond.—*The Medical Times and Hospital Gazette*, March 7th.

Treatment of Tuberculous Joints; A Surgical Demonstration. By F. J. Steward, M.S., F.R.C.S. — *The Clinical Journal*, March 11th.

An Address on Some Misconceptions with regard to Diseases of the Liver. By W. Hale White, M.D.—*British Medical Journal*, March 7th.

Prevaccinated Small-pox. By J. Duncan Howe, M.R.C.S.—*British Medical Journal*, 21st March.

A Lecture on Certain Abdominal Affections. By W. Arbuthnot Lane, M.S. — *The Clinical Journal*, 25th March.

On the Problem of Glycosuria and Diabetes. By W. Hale White, M.D.—*The Lancet*, 14th March.

Reviews.

The price of books submitted for review should in every case be stated.

The Nurse in Hot Climates. By Edward Henderson, M.D. (The Scientific Press, Ltd.) 1s.

A well-written, concise, straightforward pamphlet, which should be of considerable use to nurses before starting in India. There is a good illustration of a ingenious couch, adapted for the treatment of hyperpyrexia and heat strokes.

Histology. Catechism Series. By E. & S. Livingstone. 1s.

Part of a well-known series and guide, a good example of the type. Into a terse summary is compressed a great mass of accurate, and often out-of-the-way information.

Meningo-myeloencephalitis. A case. By Charles K. Mills and William J. Spiller.

The above excellent monograph may be found in the library, presented by the authors. It is well worth any M.B. man's perusal from an examination point of view.

Refraction of the Eye. By Ernest Clarke. (Baillière, Tindall & Cox.) 5s.

This handbook for students is one that is likely to be very useful to those who are studying the ordinary tests for vision. Great attention has lately been paid to the eye, and the oculist is apparently replacing the other specialists in popularity. The book is well-written, clear and definite, the paper and printing are good, and it is a most useful addition to a student's library. It is well illustrated and very lucid in description.

The International Text-book of Surgery. Warren—Gould. In two vols. (W. B. Saunders & Co.) Price 2s. net.

The above books form an extremely valuable contribution to surgical literature. It is an Anglo-American book, and its contributors—some fifty in number—are among the best known on either side of the water. For us it has the additional interest that it contains an admirable article by Golding-Bird and Bellingham Smith on the Surgery of the Spine.

It is a vast, comprehensive and modern work. It may not be the help to students for examinations that some other works are, but it is throughout practical and instructive. The articles on abdominal surgery, technique and diagnosis, are in every way admirable and worthy the perusal of the most advanced.

There are many small points, such as the indications for after-treatment, that are shunned or left to the individual to originate, and there are points that one may cavil at, but it is so admirable, as a whole, that we would not wish to dwell on its minor defects.

The article by the writer on abdominal surgery is most instructive, and the proportionate space devoted to various surgical diseases is a great advance on some older text-books. While the book cannot compare with Jacobson's work for the details of the risks of operations, and is, perhaps, too optimistic as regards the results throughout, we feel that it is a book to be highly commended and studied, and that it is likely to prove a valuable book to all who wish to read more deeply than the amount necessary for the college.

Biographic Clinics: The Origin of the Ill-health of De Quincey, Carlyle, Darwin, Huxley and Browning. By George M. Gould. (Rebman, Limited, London). Price 5s. net.

This most erudite work shows such evidences of careful study of the subject, and such a weird and yet indefatigable energy in the pursuit of this inquiry, that one is somewhat bewildered as to value and position of such a laborious and yet dilettanti effort. Eyestrain, hyperopia, myopia or astigmatism are held to be the causes of the breakdown, the ill-health, and even the peculiarities of these eminent authors. The work is amusing, careful and instructive. It is a bye product of medical literature and must be read to be appreciated.

Sport.

Association Football.

GUY'S v. St. THOMAS'S.

Inter-Hospital Challenge Cup—Semi-Final.

This match was played at Chiswick on Tuesday, March 3rd. St. Thomas's won the toss and Guy's kicked off with the wind in their favour. The first half was fairly evenly contested, Guy's having slightly the better of the exchanges. The forwards were well fed by their halves, but failed to score through poor shooting, and half-time arrived with no score. In the second half Guy's went away with a rush, but the ball was returned, and the Thomas's left wing ran down the field and passing well to Smith, that player scored, Crofts slipping over just at the critical moment. On the re-start Guy's attacked hotly and pressed our opponents in, corner after corner falling to us. Several of these were well placed by Foster, but it was not till within twenty minutes of time that we drew level. Litchfield put in a good centre and Piper securing the ball, eluded two opponents and scored a good goal. Shortly after, a foul was given against one of their backs within the penalty area, and Barber, taking the kick, easily scored the winning goal. Thomas's tried hard to equalize, but our defence prevailed and the whistle blew, with the score—

GUY'S	...	...	2 goals.
St. THOMAS'S	...	...	1 goal.

If we are going to win the Cup, there will have to be marked improvement in the shooting of our forwards. Foster was the best of a good trio of halves, and the backs played a sound game. Team :—

Guy's.—E. A. Collins (goal); A. G. Jones, A. D. Crofts (backs); A. L. Foster, A. F. Denning, P. C. V. Pedrick (halves); A. W. Berry, P. C. Litchfield, H. Barber, E. L. R. Norton, S. A. Piper (forwards).

GUY'S v. BART.'S.

Inter-Hospital Challenge Cup.—Final Tie.

This match was played at Chiswick on Friday, March 13th, in glorious weather. When the teams lined up at 3.15, there was a large crowd present, amongst whom we noticed a large number of the staff. Guy's won the toss, and played with what little wind there was in their favour. Immediately after the start Guy's attacked, and within five minutes, from a scramble in front of goal, one of their backs put the ball through. Bart.'s then attacked, and a free kick was given against Jones, but nothing accrued. Bart.'s continued to press, but the defence prevailed. Guy's then, by some pretty combination, ran down the field; Norton centreing to Barber, that player put in a good shot, which rebounded from goal-keeper, and Litchfield dashing up, headed into the net, amidst great excitement. Guy's were now having all the game, and Barber got clean through the defence, having an open goal. For some unaccountable reason he shot straight at the goal-keeper. Shortly after this, Berry ran down the wing, and centring to Norton, that player banged the ball into the net. Shortly after this half-time arrived with the score :—

GUY'S	...	...	3 Goals.
BART.'S	...	...	Nil.

After a brief interval the game was restarted. Bart.'s attacked. Jones tried to dribble away instead of kicking, and being deprived of the ball, their inside right had no difficulty in scoring. This put Guy's on their mettle, and Barber, gaining possession from a good centre by Piper, put in a very powerful shot, which was magnificently saved by Armytage, who was again conspicuous shortly afterwards by saving from Norton. Litchfield and Berry by some good combination again took the ball into our opponents' territory, and the last named put in a beautiful centre and Piper, rushing up, took the ball on the half-volley and scored a magnificent goal, with a difficult cross-shot. From this point to the end Guy's had all the best of the game, but Bart.'s had the misfortune to lose one of their men through an injured knee. Denning very nearly broke through and scored, and the final whistle blew with the score :—

GUY'S	...	...	4 Goals.
BART.'S	...	...	1 Goal.

Team :—

Guy's.—E. A. Collins (goal); A. G. Jones, A. D. Crofts (backs); A. L. Foster, A. F. Denning, P. C. V. Pedrick (halves); A. W. Berry, P. Colin Litchfield, H. Barber, E. L. R. Norton (capt.), S. A. Piper (forwards).

Remarks.—It is a great satisfaction to have at last brought back the Cup to the Smoking Room, after an absence of six years. Long may it remain! Our defence

was good, Jones and Crofts playing a sound game. The halves played a grand game, their tackling and passing being very conspicuous. Special mention should be made of Foster, who fed his wing men with great judgment. Of the forwards, Piper and Berry showed excellent form, and were ably backed up by their inside men. Barber was shadowed by two men throughout the whole game, but in spite of this, he played his usual sound and brilliant game. Litchfield played with a great amount of dash, his goal being a particularly pretty effort. Norton was in very good form, and kept the forwards well together.

GUY'S 2ND XI. v. ST. MARY'S 2ND XI.

JUNIOR INTER-HOSPITAL CUP.

This match was played at Honor Oak Park on Wednesday, February 23rd. Having won the toss Guy's kicked off with the wind, starting one man short.

For some time play was of a loose character, until the forwards began to work together, and then we began to press. The first point was put on from a scramble in front of our opponents' goal, and Edey quickly added a second with a good shot. Plummer appearing on the scene, we had matters much our own way, and added three more goals before half time. On making a start again, our opponents seemed to have resigned themselves to the inevitable, and before the finish five more points were added.

The game was chiefly in the hands of the forwards and halves, and the large number of goals scored was certainly due to the persevering work of the latter. Curtis, in goal, made some brilliant goal-kicks, but otherwise was a spectator. Score:—

GUY'S	10 goals.
ST. MARY'S	Nil.

GUY'S.—H. H. Carter (goal); A. Leeming, P. Honchin (backs); G. N. Plummer, A. Zorab, F. Morres (halves); P. A. Peall, H. Barlow, T. Edey, A. S. Littlejohns, C. Fothergill (forwards).

GUY'S 2ND XI. v. MIDDLESEX 2ND XI.

JUNIOR INTER-HOSPITAL CUP.—2ND ROUND.

After having defeated St. Mary's in the first round by 10 goals to nil, we met Middlesex on March 16th, and won by 2 goals to 1. Guy's were well represented, and although opposed by wind and sun in the first half of the game, soon began to press. Middlesex retaliated, and play became even, until, after a good centre by Peall, the first point was added for Guy's by a fine shot from Littlejohns. No further scoring took place in the first half.

Play now became chiefly confined to our opponents' half of the field, and several opportunities of scoring were missed by our forwards. Edey then showed a piece of his usual good form, and scored a brilliant goal. After this play languished, until roused by the taunts of some of the spectators Middlesex made a rush, and taking the backs by surprise scored. The score at the finish stood—

GUY'S	2 goals.
MIDDLESEX	1 goal.

The halves played a good game, tackling smartly and finding their forwards, but the latter did not make the most of their opportunities. The backs were rather weak, but Honchin was the more reliable. Team:—

GUY'S.—H. H. Carter (goal); V. S. Honchin, A. Leeming (backs); G. N. Plummer, A. Zorab, F. Morres (halves); C. Fothergill, A. S. Littlejohns, T. Edey, H. Barlow, P. A. Peall (forwards).

GUY'S (Holders) v. LONDON.

INTER-HOSPITAL JUNIOR CHALLENGE CUP.—FINAL TIE.

Played on Friday, March 20th, 1903, at Acton, in fine though windy weather, and in the presence of a few enthusiastic supporters, on the University College ground. Guy's once more became the holders of the above cup after beating Mary's by 10—0 and Middlesex 2—1 in the previous rounds.

London won the toss, and we started against wind and slope. During the first half our defence was kept very busy, mainly owing to the high wind which had a great effect on the light ball, but we successfully kept our opponents from becoming dangerous, and Carter in goal was not seriously troubled. We were the first to press and narrowly escaped scoring soon after the start, the full-back fisting out in the absence of the goal-keeper. Edey missed scoring from the penalty, and play was transferred. Good runs and centres by Peall, and some excellent play by Littlejohns and Edey made us dangerous on many occasions, and from a tussle in goal Fothergill just sent the ball over the line after about twenty-five minutes play, and soon after the teams crossed over with the score 1—0 in our favour.

With wind and slope to aid us, there was only one team in it, and play became very uninteresting, our opponents devoting a great deal of energy to kicking-out. Edey and Littlejohns each scored with fine shots, however, many other opportunities being missed, and the whistle blew with the score—Guy's, 3 goals; London, nil. The margin should have been greater, but the high wind and a rather flabby ball made shooting difficult. Some good combination was shown by the forwards, particularly by Littlejohns and Edey, while Peall put in some good runs and centres. The defence was very sound. Team:—

GUY'S.—H. H. Carter (goal); A. Leeming, V. F. Honchin (backs); E. N. Plummer, A. Zorab, F. Morris (halves); C. Fothergill, A. S. Littlejohns, T. Edey, H. Barlow, P. A. Peall (forwards).

REMARKS.—After a season remarkable for the amount of "scratching" done, it is satisfactory to note that the same eleven turned out in all three cup-ties. Little can be said of the goal-keeper or backs, as in none of the

games was the defence severely tried; but in the final the halves played well, feeding their own forwards well and stopping the rushes of their opponents. In the first half of the game, playing against the wind, some good combination between the forwards was seen, Peall putting in some good centres. Littlejohns was very busy also, and put in some useful work. In the second half, Edey and the left wing were prominent, Fothergill centring well, and more points should have been scored. The team was, perhaps, one of the best the Second has had for some years, and deserved to get the Cup, which will, it is to be hoped, long remain undisturbed.

SEASON 1902–3.

This season has been one of the most successful for some years, the results of matches being as follows :—

				Goals.	
Played.	Won.	Drawn.	Lost.	For.	Against.
20	12	3	6	58	35

We managed to get into the Fourth Round of the Surrey Senior Cup, but there the Clapham Rovers proved too good for us by 3—0. There has unfortunately been a good deal of "scratching," many cases being, no doubt, unavoidable, and others seemingly the reverse.

We shall be very sorry to lose the services of Norton and Barber next season, a loss which will be greatly felt as they have proved themselves to be veritable towers of strength.

United Hospitals Hare and Hounds.

SEASON 1902–3.

The last race of the season took place at Blackheath, over the five mile course twice, for the possession of the Challenge Cup, held last season by St. Bartholomew's, who were unable to raise a team this year, so that Guy's had a walk over, E. L. Pilbeam easily qualifying for the Gold medal, and Carr taking second place, followed at some distance by G. W. Lloyd, of Bart.'s, and Messent and Stott, of Guy's. W. Hall Barnett, of Bart.'s, retired. Mr. J. E. Fowler Dixon, L.A.C., took the times, and Mr. T. M. Gale, the Blackheath Harrier, laid the trail. By kind permission of Mr. H. W. Haslegrove and the other Blackheath officials, we were enabled to use their head quarters at the Green Man.

The past season as a whole has been a great advance on the past few years, as we have established a fixture list, and have a better chance of success next year than we did this. In beating the South London Harriers over their five mile course, we did really well to take eleven points off them, but owing to the team being weakened by several of the best runners in all the other matches we failed to score again, losing to Wellington College as both Gibb and Norton were absent, and to Blackheath, where Gibb sprained his ankle and Gosse strained his leg, on this occasion Guy's found first three home for the hospitals, Norton first, Carr fourth, and Pilbeam seventh. Owing to the prevalence of influenza we had to scratch to Ranelagh and Thames, but ran a weak team to Cambridge over the Gog-Magog course, where we also lost. Dublin and Oxford Universities scratched owing to their inability to raise a team.

With such promising runners as Pilbeam, Carr, Stott, and Messent, Guy's should find little difficulty in retaining the Cup in the next season or two, but we should like to see more support, as if one or two of our team are not fit, it means scratching a match, having no tail to our team. Next season we hope to see London Hospital competing for the Cup, as they are very keen at present.

As regards the team Pilbeam should do really well, with judicious training, with the Brighton and County Harriers, of which he is a member. Carr, though not as yet fortunate enough to lead the field home, has never missed a single fixture, and has always scored for the club, thereby proving of infinite value to the club. We hope to hear great things of Stott, and perhaps of Messent next season, though I fear the latter finds football too much of an attraction to give him much time for cross country work.

G. W. Lloyd, of Bart.'s, has, like Carr, turned out most consistently, while, of course, J. G. Gibb, of Bart.'s, is undoubtedly the best man we have had, with one or two notable exceptions, since the days of H. A. Munro.

Solution to Case for Diagnosis.

Operation on March 17th, 1903, by Dr. Horrocks. A considerable quantity of ascitic fluid was found in the peritoneal cavity. The left ovary was found to be involved in a large solid tumour, which weighed just over five pounds, and which measured about ten inches laterally, by eight inches vertically. In an antero-posterior direction it also measured about eight inches. It showed all the characteristics of sarcoma. The centre of the tumour showed signs of breaking down. The right ovary was also found to be the seat of another growth, about the size of a cricket ball, and weighing about a pound. Both tumours were exceedingly vascular. There were no signs of secondary deposits. The growth involving the left ovary was the one which had been felt by palpation, the smaller tumour lying posteriorly.

At the present time the patient is suffering from parotitis, which came on three days after the operation; otherwise she is doing well.

The diagnosis of malignant ovarian was thus confirmed.

Birth.

MARSH.—On March 14th, at St. Martin's, Aldington, Hythe, the wife of H. Rupert Marsh, L.R.C.P. Lond., M.R.C.S., of a son.

Ed.—J. M. B.

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Calendar of Coming Events.

April, 1903.

Sat. 11.—Messrs. Golding-Bird and Dunn's take-in; Drs., A. E. F. Kynaston and R. M. Beadnell; Cl., N. I. Spriggs.

Sun. 12.—Easter Day. Services in Chapel at 6, 7, 8.45, and 11 a.m., and 7 p.m.
Preacher at 11 a.m.—The Right Reverend the Lord Bishop of Southwark.

Mon. 13.—Easter Monday. Medical School Office closed.

Tues. 14.—Final Conjoint Exam. begins.
Second Part of Cambridge D.P.H. Exam. begins.

Thur. 16.—Messrs. Jacobson and Fripp's take-in; Drs., E. Lloyd and F. W. M. Palmer; Cl., R. S. Anderson.

Fri. 17.—Third and Final M.B. Durham Exam. begins. Exams. for M.D. and M.S. Durham begin.

Thur. 23.—Messrs. Symonds and Stewart's take-in; Drs., G. E. F. Robinson and G. H. Rees; Cl., G. E. Malcomson.

Guy's Hospital Gazette,

APRIL 11, 1903.

On Acute Inflammatory Conditions of the Tympanum.

CLINICAL LECTURE BY MR. FAGGE.

December 8th, 1902.

GENTLEMEN,—I propose to discuss to-day the subject of acute middle ear inflammation. It is a subject with which in the future you will have a good deal to do, and about which you may in reading text-books be much confused, because of the frequent confusion of terms under which it is dealt with.

German writers on the subject carefully differentiate cases of one type under the heading of acute middle ear catarrh, and those of another, under the heading of acute middle ear inflammation, or otitis media. We do not seem to be justified from our pathological knowledge, which is unfortunately or fortunately not very extensive, in making this distinction, but we seem to be able clinically to broadly classify these cases under four headings, though it must be clearly understood that these divisions are arbitrary, that many cases lie on the border line between two of these headings, and sometimes a case which at one time seems to come into one class may undergo an exceptional change into another class.

The headings which I would suggest as helping us to understand this disease, are (1) simple acute catarrh, (2) sero-mucous catarrh, (3) acute purulent inflammation (otitis media acuta) (4) hæmorrhagic otitis.

Perhaps we may clear the ground a little if we deal briefly with the last class first and characterise these cases as of a very acute type, associated commonly with influenza as causative factor, tending to the formation of a sanguineous fluid collection in the tympanum, which after a short period of acute pain, end in rupture of the tympanum. In many particulars it will be seen later that this class approaches the third class, but points of distinction would be its influenzal causation, its occurrence in adults rather than in children, and the relatively greater frequency of acute intra-cranial mischief in this form.

I think you will appreciate that practically the first three classes are only different stages of the same disease, the first the least, the last the most severe, associated with a corresponding intensity of symptoms.

The classical symptoms of all the forms are pain in the ear, deafness, which is sometimes no more than a sense of dulness or thickness, and noises which may be throbbing or a continuous hum.

Before discussing the first symptom, that of pain, it will be well to remind ourselves that ætiologically these affections are most commonly seen in children and are due to atmospheric influences such as colds or influenza, the acute

exanthemata and syphilis, being most frequently an extension upwards of an acute infection of the nasopharynx through the Eustachian tube to the mucous lining of the middle ear.

There is no definite knowledge as to the organisms producing the changes in the middle ear which occur in those cases which pass naturally on to resolution, but in those which require paracentesis, and from which the exudation can be microscopically examined, it has been repeatedly shown by Zaufal, Weichselbaum and others, that the diplococcus of pneumonia (Fränkel Weichselbaum) or streptococcus pyogenes is most often present, while in the acute otitis of newly-born infants the gonococcus is frequently found, and in other acute cases the tubercle bacillus has been recently observed in a much larger percentage of cases than was previously supposed.

The most tangible symptom is pain, and it will be in young babies the only one obtainable, usually evidenced by a tendency to rub the ear or frequently raise the hand to the ear. In children old enough to describe their pain intelligently, it is usually said to be a deep seated throbbing pain, unrelieved by pressure, but relieved by heat, often oscillating so that it may temporarily improve, and yet in the severe cases gradually becoming more and more acute until it is relieved by perforation of the drum.

I trust you will not carry away the idea that all pain in the ear is due to this cause, for on the contrary, in a large number of the cases of earache, seen in a large out-patient department like Guy's, it is due to foreign bodies impacted in the meatus, or as referred pain due to carious teeth and to many other causes; a careful examination of the ear after noting the symptoms, can only decide upon the differential diagnosis here.

Not only does the amount of pain vary much in the different stages of the disease, but also very much in different people; one is always armed with the suspicion that cases of middle ear inflammation which have reached the most acute stage, or even gone on to perforation without pain, may be due to tuberculosis in which this is the characteristic course of the disease. Yet it is extraordinary how commonly one is told that children who come up to the hospital with acute middle ear suppuration, have not complained of pain, and the same is true of those cases, even in adolescents, in which an old healed perforation has again given way during a recurrent attack of inflammation.

Associated with this pain in the more acute varieties, deep tenderness on pressure is often found over the tip of the mastoid process, and the position of this tenderness must be carefully differentiated from that higher up over the mastoid antrum in acute antral inflammation, or from tenderness below the lobule, in front of the tragus, or around the auricle in inflammatory conditions of the meatus.

Deafness is usually marked, and is in itself with its sudden onset, a help in diagnosis from the early stages of meatitis. When we carry out the usual tuning-fork tests on a patient with acute middle ear inflammation, we find that the fork is heard better when placed upon the mastoid process than when held near the external auditory meatus: this is known as Rinné's test, and the variation spoken of above is known as negative Rinné, as opposed to the normal condition in which the fork is heard better near the meatus (Ms) than when placed upon the mastoid process (Md) (positive Rinné) *i.e.* Ms > (= greater than) Md.

We may briefly state that a − Rinné (Md > Ms) indicates usually that deafness is due to a lesion of the conducting apparatus, *i.e.*, the meatus or the middle ear, whereas with deafness a + Rinné indicates that the internal ear is affected; but it is necessary to remind you that a single fork test, as for instance with the usual fork (C 512 vibrations) is sometimes unreliable, and accurate testing with a series of C forks may give a different result, and also that in acute middle ear affections Rinné may remain positive; that is meatal hearing will be greater than mastoid hearing, the reason of this I do not know, nor can I give you an accurate explanation of Rinné's test itself.

If we now alternately place the tuning fork on the patient's mastoid process and on our own mastoid, we find that when the patient's Rinné is negative, he will continue to hear the tuning fork on his mastoid when the observer can no

longer hear it on his, we then say that Md is +. A very easy illustration of this and its indication are obtained by placing the fork on one's mastoid, and when it can be no longer heard, closing the meatus on that side with the finger when the fork will again be heard. It is clear that Md + indicates like a negative Rinné obstruction to conduction. This is called Schwabach's or Gardiner Brown's test.

In order to apply our confirmatory tests let us assume that the patient hears a 50-inch watch with the right ear 2 inches distant, and with the left at 50 inches distant.

That Rinné is − on the right and + on the left, that Md is + on the right and normal on the left; if we then hold the tuning fork with its base over the middle line of the skull, the patient would refer the sound to the *right*, that is the affected ear, and this, I think, you will agree follows Schwabach's test and is known as Weber's test. This test is only useful when only one ear is affected, or is affected more than the other. When both are equally affected the result may be indefinite, the sound being heard equally in both ears.

Its importance is shown in that if our patient had a lesion of the right internal ear, the fork would be referred to the *left*, that is the sound ear, giving us a very great help in the differential diagnosis of internal from middle ear deafness, as I have said, when the ears are unequally affected.

The above are rather intricate when one rapidly reviews them in a lecture, but will after a little practice be easily comprehended; they are sufficiently reliable for ordinary purposes, and should be carried out as is done in the Out-patient department on every patient troubled with deafness. Such careful observations will save much trouble and many mistakes in diagnosis later.

The result supposed to be gathered from the case above may be briefly expressed as follows:—

	Right.	Left.
Watch (w)	$\frac{2}{50}$	$\frac{50}{50}$
Tuning fork	Md > Ms : Md + .	Ms ≥ Md : M nl.
Weber	referred to right.	

which confirm one another in a diagnosis of some lesion of the conducting apparatus of the right ear.

Noises in the ear usually bear the character in the more acute cases of throbbing sensations, due no doubt to vascular congestion: in the variety in which there is a sero-mucous exudation into the tympanum, a continuous tinnitus is often met with which is probably produced by a temporary increase of pressure in the labyrinth. Politzer first drew attention to the frequent sensation as if a body were moving to and fro in the tympanic cavity, when the position of the head is changed, which is characteristic of recent exudative catarrhs corresponds to the motion of the exudate. Another sensation often met with is a cracking or snapping sound produced by swallowing or mastication.

These subjective sensations, associated with marked deafness of sudden onset, or a sense of numbness and fulness, and with but a slight amount of pain, are characteristic of the slight forms of inflammation, and, as I have before mentioned, serve in the first place to suggest middle ear catarrh rather than an inflammatory condition of the meatus in which deafness is at first absent, and pain almost always marked, but of course diagnosis can only be completed by an examination.

Constitutional disturbances are not usually present except in the most acute forms of acute inflammation, when commonly in children pyrexia extending to 102° or more, with anorexia, delirium and even convulsions are met with, and I have been several times struck with the severity of constitutional symptoms in acute otitis in children in whom the amount of pain complained of, and the comparatively slight amount of attention drawn to the ear, did not suggest so acute a condition until the ear had been examined.

Well authenticated observations have shown that optic neuritis may result from a simple acute purulent otitis media with an intact drum and without intracranial complications.

In simple acute catarrh, when we examine the membrane, we usually find a varying amount of injection, in one case simply amounting to an unusual congestion of the vessels lying along the

handle of the malleus, and in a more marked example extending to a general pinkish congestion of the whole membrane. There is no alteration of the natural indrawing of the membrane, and the malleus is not obscured to the view, but the whole drum appears less translucent than normal, and the cone of light which normally passes downwards and forwards from the tip of the handle of the malleus is absent.

In the cases of sero-mucous exudation, the same appearance is presented, but in those in which the normal membrane has a well-marked transparency one may see a distinct horizontal line of demarcation extending across the drum, marking off the upper limit of a dark yellowish area of exudation below from the pinkish gray area above. This appearance is not common, and is better marked in those sero-mucous catarrhs which are approaching a chronic stage after an acute onset.

In well-marked cases of exudation the congestion of the drum is more marked than in the simple form, and the membrane is less concave, giving the appearance of fulness of the tympanic cavity.

A typical case of the third stage, which has not yet gone on to the formation of pus in the middle ear, presents a most bewildering appearance when it is seen for the first time, for we find that the œdema and congestion of the membrane is greater, that the exudation in the middle ear has increased and become hæmorrhagic, so that the membrane now assumes a dull purplish crimson appearance, and is markedly convex or bulging in front and behind the malleus, so that the position of the malleus is obscured, and it is quite difficult to be sure what one is looking at, for the short process and handle of the malleus, our chief landmarks in inspection of the drum, are not seen, and to one not practised in ear examination, as I well appreciate, the appearances are most confusing.

In a later stage, especially when treated by watery instillations, one finds the external epithelium of the membrane sodden, and patches of greenish yellow discoloration over the most prominent parts of the membrane, indications that perforation following pus formation in the tympanum is imminent.

If we now continue our examination to an inspection of the nose and nasopharynx we may commonly find an acutely swollen condition of the nasal mucous membrane, with profuse watery or muco-purulent exudation associated with a general inflammatory swelling of the nasopharyngeal mucous membrane: here we have, as I have said before, the causation of our middle ear trouble. In those patients who are old enough to allow of examination of the nasopharynx with the mirror, you will notice much swelling of the Eustachian orifice which may contain some yellowish exudation, but whether you examine with the mirror or with the finger from a point of view of practical value, by far the most important point to determine is the presence or absence of post-nasal growths or adenoids. Whenever you have a child or adolescent, in whom colds are frequent, in whom every attack of cold flies to the throat and is in every case associated with deafness, for which you are asked your opinion, do not decide against the presence of adenoids until you have either have seen with the mirror or felt with your finger an empty post-nasal space; and the reason is this, that when undetected adenoids are present, though by proper management the acute attack of inflammation may pass off, it will very probably recur, possibly next time in a more acute form, followed by perforation of the drum and chronic suppuration, and almost certainly by a more marked degree of deafness, which, when that attack subsides will leave the patient deafer than he was before it.

Usually, besides the frequent taking cold and deafness, one has in children other symptoms, such as mouth breathing, persistent anæmia, night terrors, defective speech, etc., to help one in the diagnosis of adenoids, though the typical nasal voice is so often absent, and parents, even in the better classes, are so absolutely wanting in powers of observation that one can only prove these things for oneself by a definite examination. One point further I would like to warn you upon; I have been surprised in the last five years to find, after what one reads in books and the pretty pictures one sees, that not five per cent. of the children with adenoids producing deafness or

other ear symptoms have what is called the "adenoid face." There is no greater fallacy than to be guided as to the presence or absence of adenoids by the patient's face, this of course is well-known, but not sufficiently well-known, and as far as it concerns the aurist the reason seems to me to be bound up in the exposure of another old fallacy. We are often told that adenoids cause deafness by pressing on the orifice of the Eustachian tube, from which we would argue that it is a mechanical process, and that, therefore, the greater the amount of adenoids the more the deafness; this on personal observation does not prove to be true. For it is now well-known that adenoids cause deafness by setting up local inflammatory swelling of the Eustachian tube and nasopharynx, and that in the majority of cases ear symptoms are present in cases in which there is a soft irregular vascular easily inflamed mass of adenoids, and not in those in which the adenoids consist of a large hard smooth mass, and I think you will see that this is opposed to the mechanical theory and also to the suggestion that any definite facial aspect is typical of and almost necessary for the presence of adenoids, for between the attacks of pharyngeal infection the adenoids loose much of their congested and swollen appearance, and nasal respiration is not continually completely interfered with so as to produce any alteration in the face.

Other causes of nasal obstruction such as hypertrophy of the turbinal bodies are neither so often met with in children, the usual subjects of the disease we are discussing, nor are so commonly a cause of middle ear catarrh.

The natural results of this complaint differ much in the four stages, and it is for this reason that I have spent some time in the effort to illustrate its varying intensity. Everyone is acquainted with the easy way in which natural resolution sets in in a slight case of middle ear catarrh, by a gradual cessation of the inflammatory trouble in the nasopharynx, restoration of patency of the Eustachian tube and a return of hearing power.

A more evil result is the passage of the catarrh into the chronic stage most often seen in those cases of chronic bilateral catarrh having a common origin in the nasopharynx, which has not been dealt with or in cases of sero-mucous catarrh, where treatment has not been efficacious in removing the exudate which becomes organised in the tympanum with the formation of adhesions producing permanent deafness.

The chief danger to be feared in the acutest cases is that the sero-sanguineous exudate should become purulent with resulting perforation of the drum and the onset of middle ear suppuration.

Occasionally one sees, more especially in children, that perforation of the drum does not take place, but that the inflammatory process extends backwards to the mastoid process, and sets up an acute mastoid abscess, while the drum is still intact.

Intracranial complications are not common as a result of acute otitis, only 9 per cent. of cerebral abscesses occurring during the stage of acute middle ear suppuration, and fatal results from meningitis or serous phlebitis are only slightly more common.

We will now pass on to treatment; in cases of simple catarrh, unassociated with much pain or signs of exudation, prompt use of Politzer's bag several times, to completely open the Eustachian tube will often procure immediate benefit both in the objective sensations, the relief of pain, and in the restoration of hearing, and the same is true of those cases in which sero-mucous exudation is a prominent feature. You are, no doubt, well aware that the classical method of using Politzer's bag is to inflate the middle ear by compressing the bag with the nozzle introduced into the patient's nose, while he by the act of swallowing a mouthful of water makes the tube patent; it can also, perhaps more easily, be carried out when the patient inflates the cheeks, or in children when they pronounce loudly a word or when they cry.

The result of Politzerising should always be confirmed as it is being done by the introduction of a rubber tube called an auscultation tube connecting the observer's meatus with that of the patient, and by inspection of the drum after inflation when the congestion will be noticed to be lessened, and in cases where exudation in the tympanum has been observed it will now often be seen to be mingled with air bubbles.

The use of Politzer's bag must be continued daily for a few days and afterwards at longer intervals until hearing is completely restored.

General treatment to the coryza, if such were the primary cause must also be carried out, with, if possible, the use of a chlorate of potash gargle for the nasopharynx, or the local application of a perchloride of iron and glycerine mixture with a brush, or the use of steam inhalations to which is added vapour of oil of eucalyptus or of tinct. benz. co.

Adenoids, if present, must be removed after the acute attack has passed off, but not in the acute stage.

In the acute stages where pain is a marked feature, it seems best to avoid the application to the membrane of warm watery mixtures, for the reason previously given that they tend to make the external layer of the drum sodden and predisposed to perforation; far better is the external application of dry heat in the form of the old fashioned bran bag or hot flannels, or well wrung-out hot lead and opium fomentations, and it is very useful to add to this frequent instillations of glycerinum acidi carbolici, B.P., as warm as the patient can bear them, which serve a double purpose as relieving pain both by their heat and their anæsthetic action of the carbolic, and also help to purify the meatus in case paracentesis may later be deemed necessary. Leeches in front of the tragus often give good results by seeming to relieve congestion.

Local applications, however, will not infrequently fail to relieve the pain, when tinct. opii. in full doses or nepenthe must be given internally. As far as my experience goes all other narcotics are useless in the alleviation of acute earache, and opium will sometimes fail.

The most valuable aid in treatment in the acute cases is paracentesis of the membrane. It is called for in two classes of cases, firstly those of sero-mucous catarrh in which the use of Politzer's bag and of nasopharyngeal treatment for several days has failed to cause the absorption of the exudation, in these it seems to shorten the duration of treatment, and secondly in cases of acute otitis media where exudation and pain increase rather than diminish, and where the increasing bulging of the drum threatens the formation of pus and perforation.

It is difficult to give a time limit to palliative treatment before performing paracentesis, but as a rule acute cases with fever which after twenty-four to forty-eight hours of treatment show no signs of subsiding are most suited for this line of treatment.

I want to make it quite clear that you are not opening a purulent collection, but are incising a cavity filled with sero-sanguineous exudation which will, if left alone, become purulent. Any one working on ordinary surgical lines would open the drum where the yellowish discolouration of the most prominent parts indicated that pus was already forming, but it is in the earlier stages that I advise you to perform paracentesis, and I wish thoroughly to drive home its value in relieving pain, preventing the formation of pus, and perhaps the beginning of a long course of chronic middle ear suppuration.

Here prevention is far better and far easier than cure, and every case of middle ear suppuration indicates a lost opportunity of prevention by paracentesis, which, unfortunately, though often due to the ignorance and negligence of patients and their parents, is not always due to these causes.

You can operate without an anæsthetic, instilling, if you will, a few drops of 20 per cent. cocaine into the meatus, but with an inflamed drum cocaine has little effect; it is far better to give gas or a general anæsthetic, the disadvantage of the former in the point of time of anæsthesia being in some measure counterbalanced by the fact that you have the patient in the sitting position in which observation of the field of operation is more easy.

Be careful first to use a very sharp paracentesis needle—a bayonet shaped handle with a small arrow head is the form I prefer. Be careful to carefully cleanse the meatus and render it as aseptic as possible, or a secondary infection with staphylococci from the meatus will result. Be careful to locate with a good light the point at which you intend to incise the drum, and then take care that on the one hand you cut deeply enough to incise the whole membrane, and not only the external swollen cutaneous

layer, and yet not so deeply as to wound the promontory or the other structures on the inner tympanic wall. As regards the best position for paracentesis, if the meatus is straight and the anterior inferior segment of the drum easily seen, incise there because here the tympanum is widest, but if this cannot be seen then incise in the posterior inferior segment, taking care to avoid the handle of the malleus and the incudo-stapedial joint.

Performing the operation under gas or without an anæsthetic has the advantage that you can immediately inflate with Politzer's bag and not only confirm the fact of paracentesis, but also remove much of the sero-sanguineous exudate.

Healing will take place within a week as a rule, during which time the meatus should be packed with sterilized or cyanide gauze, which is changed daily when the meatus is mopped out or syringed with sterilized water, or one in sixty carbolic solution made with carefully boiled water, and during and after this period the occasional use of Politzer's bag will be found beneficial.

I would like you all to take the opportunities afforded here of learning to perform paracentesis, for until every medical man can easily carry it out chronic suppuration will provide as alarming a majority of our cases of intractable deafness as it does at present.

Chapel News.

The Services on Easter Day will be as follows:—The Holy Communion will be celebrated at 6, 7, and 8.45 a.m. Morning Prayer and Sermon at 11 a.m. Evening Prayer and Sermon at 7 p.m. The rule of the Prayer Book is that every communicant "shall communicate at the least three times in the year, of which Easter to be one."

The Bishop of Southwark will preach at 11 a.m. on Easter Sunday.

Our thanks are due to the special preachers in Lent and Holy Week. First to our Chaplain, the Bishop of Rochester, who came for the third year in succession on Ash Wednesday night; to Canon Brameld, who preached on three Tuesday evenings; to Canon Moberly, to the Rev. G. F. Russell, and lastly to Canon Taylor, who has preached on the first four evenings in Holy Week. All of them are busy people, and we are very grateful to them for coming to us. The attendance at these services has been very good, but perhaps the best part of Lent has been the increased and regular attendance at the Communion Service both on Sundays and week-days.

The singing in Chapel at the Sunday services has steadily improved since the formation of the Students' Choir, and they have added greatly to the spirit and life of the Chapel Services. Mr. Tipping acted as Honorary Secretary for the first four months, and his place has now been taken by Mr. Felton.

Notice.

UNIVERSITY OF LONDON.

ROGERS PRIZE, 1904.

Under the Will of the late Dr. Nathaniel Rogers, the Senate offer a Prize of £100, open for competition to all the members of the Medical Profession in the United Kingdom, for an Essay on "The Relation of Tuberculosis and Streptotrichosis from a Pathological point of view."

Essays, by preference typewritten or printed, must be sent in not later than February 29th, 1904, addressed to the undersigned,

PERCY M. WALLACE, M.A.,
April 2nd, 1903. Secretary to the Senate.

Nursing News.

Matron's Office.

On March 19th, Nurse Milman left the hospital on completion of her three years' training, and Probationer Hamlin was appointed to succeed her as Head Nurse in Mary ward.

On March 19th, Nurse Earp left the hospital on completion of her three years' training, to take up her duties on the Private Nursing Staff. Probationer Hayward has been appointed to succeed her as Head Nurse in Dorcas ward.

On March 21st, Nurse Baynes Reed left the hospital to take up the appointment of Matron at the Cottage Hospital, Warminster. Probationer Wise has been appointed to succeed her as Head Nurse in Naaman ward.

On March 24th, Nurse Guthrie left the hospital on completion of her three years' training, and Probationer Nawn was appointed to succeed her as Head Nurse in Stephen ward.

On March 27th, Nurse K. Neale, Head Nurse in Victoria ward, left the hospital on completion of her three years' training.

On March 28th, Probationer E. Densham was appointed Head Nurse in Miriam ward.

Nurse Vivian, Head Nurse in the Surgery, left on March 31st, and Nurse Leslie, Head Nurse in Bright ward, on April 6th, having completed their three years' training.

The following Nurses and Probationers have passed the examination in Materia Medica and Pharmacy, held on March 28th:—Atkey, Aitken, Abbott, Bellis, Bell, Brown, Browning, Barker, Byrne, Campbell, Coates, Cornwell, Cowie, Du Boulay, Densham, Denton, Eastmond, Edmonds, Foster, Gilbert, Grigor, Hamlin, Harden, Haslar, Heritage, Hopkins, E. Humpherys, Hayward, Jones, Lokier, McFarlane, McKenzie, Morley, Mortiboys, Morton, Mott, Nawn, Plant, Pearse, Porter, Pritchard, F. Scott, E. Smith, F. Smith, Seccombe, Shewell, N. Stanton, Spink, I. Thomas, J. Thomas, Tweedie, Woodward, Whittam.

Correspondence.

To the Editor of Guy's Hospital Gazette.

University of London, "Neutral Diplomas."

Dear Mr. Editor,—I have received a number of enquiries, in reference to the notice in "Passim" of March 28th, from some of our students who took their degrees in 1901 or 1902, as to whether there is any advantage to be gained by exchanging the Diploma granted to them as an "External Student," for a "Neutral" one, or by applying for a "Neutral" Diploma, *i.e.* one without reference to the distinction between an Internal and External Studentship.

The enclosed letter, received from the Academic Registrar, explains the position, and I will ask you therefore to be good enough to publish it in connection with this one. The time up to which such certificates must be sent in has been extended. The certificate with the "External" Diploma must reach the University *before April 20th next.*

I may here take the opportunity of stating what is meant by "Internal" Student and how it is that those Internal Students who graduated in 1901 or 1902 were only granted degrees as "External Students."

A Student who has Matriculated and attended an approved course of instruction in a School, or under any one recognised Teacher of the University, can be registered as an "Internal Student," but no person can take a Degree as an "Internal Student" until he has completed an approved course of study comprising all the subjects in which he presents himself for examination, and extending over not less than three years from matriculation. As the University was not reconstituted until October, 1900, it is obvious that those who took degrees in 1901 and 1902 could not have fulfilled these requirements, and therefore, they were classed as External Students.

The Senate, however, after considering the question of the hardship entailed upon Students in Schools of the University who commenced their course of study before the reconstitution of the University in October, 1900, and who graduated in 1901 or 1902, being described as External Students upon their Diplomas, adopted the resolution printed in the last number of the Guy's Hospital Gazette, allowing such graduates to have "Neutral" Diplomas granted them should they desire.—

Yours very truly,

J. FAWCETT,

To the Editor, Dean.

Guy's Hospital Gazette.

University of London,
South Kensington, S.W.,
April 2nd, 1903.

Dear Sir,

In reply to your letter of yesterday, in reference to the Diplomas which it is intended to issue containing no mention of the distinction between Internal and External Students, I beg to inform you that the latest date for sending in Certificates to the effect that Students are eligible for such Diplomas will be extended until the 20th inst. I regret that it is not possible to prolong this period, since the Chancellor must sign all the Diplomas before Presentation Day.

I have to say further, that in the Faculty of Medicine the distinction between an Internal and External Student is one dependent upon the place rather than upon the manner of study. But this, as you will understand, is by no means the case in other Faculties, where, the fact of having pursued a Course of Study at a School of the University or under Recognised Teachers is peculiar to Internal as opposed to External Students. In the Faculty of Medicine this distinction does not hold, for all Students, whether Internal or External, must take an Approved Course of Study—Internal at a School of the University; External elsewhere.

From this it follows that a Student preparing for a Degree in Medicine at a Medical School *in London* recognised by the University, is an Internal Student, while the External Student in Medicine is one who is working for the Medical Degree of the University of London, but not *in* London.

It was impossible to distinguish between the different Faculties in making arrangements for the neutral Diplomas, and for this reason Medical Students have, no doubt, felt some hesitation as to the desirability of applying for them.

Faithfully yours,

H. FRANK HEATH,
Academic Registrar.

J. Fawcett, Esq., M.D., Dean,
Medical School, Guy's Hospital, S.E.

Passim.

We wish to draw attention to the Dean's notice *re* London Diplomas. We would not influence any but point out that in future Guy's men will be designated *Internal* Students and that they had better take the Neutral Diploma than one labelling them as *External* Students, and so distinguish them from all future Guy's M.B.'s.

There appears to exist some doubt as to the subscription and position of the Gazette and the Guy's Hospital Reports. The Gazette may be obtained, post free, by anyone, including all the twenty-five copies and the prints, reproductions, photographs, and Christmas picture, for seven-and-sixpence, or six-and-sixpence without postage. There is in existence an arrangement by which the Clubs' Union for twelve-and-sixpence will supply the Gazette, as above, and the Reports post free. The Reports, post free, are ten-and-sixpence to outsiders, six shillings to subscribers and life members of the Clubs' Union. The members of the Clubs' Union are entitled to a copy of the Gazette for five years, after which time they may compound and obtain the Gazette and Reports for twelve-and-sixpence, or the Gazette alone for seven-and-sixpence, or the Reports alone for six shillings. Purely from the Gazette point of view a subscription to the Gazette direct is preferable to the combined subscription, for which the Gazette only reaps five shillings, but we hope all old Guy's men will endeavour to keep up their interest in the hospital by taking the Gazette, and their interest in its professional work as evidenced by the well-known Reports.

So many enquiries have been made about the subscriptions to the Reports that we here re-state the present arrangement. Any old Guy's man who desires it (and we hope all will take it for the good of the Hospital and Medical School) can secure the entire issue of the Gazette, twenty-five numbers, fortnightly, except in August, with all the reproductions, photographs, and Christmas picture, post free, by sending that seven-and-sixpence to Mr. C. H. Wells. Twelve-and-sixpence together will entitle him to the Reports for the year and the Gazette, or the Reports alone may be had for six shillings.

A recrudescence of the disease of typhus in Jamaica Road, some half dozen in all, has given some of the present generation an opportunity of diagnosing this rare and archæologically interesting disease. The most interesting points about two cases were that the medical officer promptly diagnosed it, and that it presented a peculiar and most remarkable smell, which we are informed was typical. The extinction, or practical extinction of typhus, the scourge of jails and overcrowded dwelling-places must, we suppose, be attributed entirely to modern sanitation and hygiene, but we rather doubt if the overcrowding and squalor in some parts differ from what it was before by much. The factors, anent the causation of epidemics, are still but little ascertained, and we may yet see, some day, a revival of this almost unknown disease. It will be very interesting to know if the present cases can be traced to typhus infected clothes, as was the case in the last outbreak we had to deal with some three or four years ago.

The allotment of four beds in the Eye Wards to ear cases under the care of the Aural Surgeon is one that is to be welcomed. Exactly under whose care the cases will be in the absence of the Surgeon is not absolutely certain, probably they will be under the Ophthalmic House-Surgeon. This alteration opens up a splendid prospect and we hope the suggestion will be considered.

By arrangement of the Out-patient days it might be possible to add the not over exacting duties of the Ophthalmic House-Surgeon, the duties of Throat House-Surgeon, and Ear House-Surgeon with attendance on them at Out-patients and care of them in the wards. If this was the case we expect the run on the appointment would be very great, and it should be a three months' appointment instead of six, because the work will be harder and the shorter term will give more opportunities without, we think, much decreasing the value.

With the appearance of Spring the park resumes its former appearance, and the old game of the sowing the ground by the gardeners and unpicking the seeds by the sparrows progresses gaily to the mutual satisfaction of both parties. In the far corner, between the anatomy laboratories and the physiological, the "chunk of old London Bridge" is in progress of re-erection on a spot that at present is not to be built on. To this spot perhaps the Eye ward smoker will wind his way with his cronies of yore and discuss the affairs of the nation with the gravity and solemnity for which they have always been famous, a peaceful existence whose monotony is only broken by sommonses to meals and prayers.

The arrival of the first quarter-day brought, as usual, several terms of office to a close. Since January 1st we have lost Capt. Brailey, the recent Property Manager and actor in the Theatricals; Mr. Glover, a well-beloved and most cultured Charity, familiarly but respectfully addressed as the "Second Strongest Man on Earth"; Mr. Tuohy, Mr. Bowen and Mr. Brown; while Messrs. Robson and Atkins, both House-Physicians, have yielded their places as President and Vice-President. To them have succeeded Messrs. Ransford, Wall, Gray, Richards, Thompson, Hodgson and Wrench. Mr. Wetherell was elected President and Mr. Barber Vice-President.

The fashion of writing short notices of the achievements of the on-coming Residents which was dropped somewhat suddenly some years ago, had something to recommend it, and appealed to popular taste. Personalities, alas, remain the most interesting of any communications, and many men will read the tale to detect, if possible, the secret of success. Perhaps we may be pardoned if, without harking back to such a custom, we point out without extravagance some notables among the residents, apart from their professional attainments.

The President has had a most marvellously fortunate career. He was in a winning Cricket Cup team, captained the famous Rugger team, and played in the County Championships for the winners, Kent. He has also represented the hospital at Tennis. The Vice-President has played in winning Cricket and Soccer teams—for Yorkshire at cricket and his county for football—and plays other games. Out of twenty-two House Appointments, men with hospital colours hold eleven, including three Rugby Captains, two Cricket Captains, one Tennis Captain, and holding sixteen colours among the eleven. In fact, the present lot of Residents and A.H.-S.'s would be hard to beat at most sports, particularly at tennis.

Our heartiest congratulations to Messrs. Hammond and Curtis on their marriages. Mr. J. A. B. Hammond was House-Physician in 1902, President of the Residents, and Editor of the Gazette, and has now settled in partnership in Shanklin, Isle of Wight. Mr. F. Curtis was demonstrator of Anatomy, House-Surgeon to Mr. Jacobson, and Charity to Dr. Horrocks, and has now settled in partnership at Reigate. We shall be glad to hear and publish any other settlings in partnership or practice, or change of address, of old Guy's men.

An unusual case was seen recently in the Surgical wards. An ordinary hernia was reduced by a medical man and sent up here. He seemed perfectly fit, and was offered the chance of a radical cure after proper preparation. He accepted, and was apparently perfectly fit and comfortable. The day of the operation he was quite ill, and at the operation the surgeon was horrified to find a reduction en masse of more than three days' standing, with two feet of gangrenous gut. The fact that the state of affairs was unsuspected till quite the end is due to the extremely insidious nature of the symptoms. Reduction en masse is extremely rare, and we believe on no single occasion has it been effected by any manipulation within the Hospital. Vol. lvi. of the Reports contains an excellent store of information of this subject.

Another interesting case which we hope to publish later on is that of generalised peritonitis admitted into Clinical, which was found to be a leaking pyosalypinx together with apparently a primary ovarian fœtation, but the specimen is not yet definitely docketed.

We congratulate Mr. Symonds on his appointment as Examiner in Surgery to the University of London.

Post-Operative Treatment of Abdominal Section.

A paper read before the Physical Society on February 10th, 1903, by J. M. Brydone, M.B., B.C., Resident Medical Officer in Bright, and awarded the Society's Prize.

Gentlemen,—When your courteous and indefatigable secretary gave me the opportunity of reading a paper before this ancient, honourable, and learned society, my gratitude was unmingled then with any sense of labour or worry attaching to the fulfilment thereof, and in fulfilling the task I found myself confronted with three main alternatives.

Following ancient precedent, I might attempt the scientific treatise, the abstruse research, the recondite and bewildering theory combined with scholarly exposition that has marked so many papers in our historic archives; but this was not in my inclination, nor indeed within my power, so I perforce was driven to consider the second course, namely, to attempt a sort of literary dilettantism, an "airy nothing and a name," researching for humour and wit among the ancient stores of Greek and Latin learning, quoting such cases as the Greek women offering the extirpated uterus as a sacrifice to Æsculapius, and dwelling on the high degrees of scientific mutilation that South African, Egyptian and Greeks attained to equally with their modern representatives—to point the moral and to adorn a winter's tale. But wit and the sorry grace of humour are ever afar from a man of Scotch descent, and so I was driven to fall back, and I hope with profit, to the consideration of the sum of our own everyday experience, to in some sort compare notes, to invite criticism and provoke reflection.

I might, it is true, have inflicted upon the unsuspecting society the paper I prepared two years ago on "Neuromimesis," but I fear its production at this epoch would provoke wrath and recrimination, so I have offered you the observations of personal experience, or, if you will, the gleanings, to quote our clerical friends, of personal ministry or perhaps merely the reflections of prejudice.

There is, I believe, no department of surgery in which greater advance has been made in the last ten years than in abdominal operations, and certainly there is a much greater knowledge of the appropriate lines of treatment, a more sensible appreciation of the rationale, and a greater tendency to follow broad lines of treatment and to disregard quaint theories of which I might give many amusing examples.

After-treatment in Homes and Hospitals is infinitely more successful than in houses even when a hospital régime has been instituted, and it is owing in the main to the observation and care of the resident surgeons and the trained home sisters that the treatment which has been evolved by experience is so intelligently and successfully applied. In other words, the after-treatment is one that can only be done properly by the man on the spot.

Before beginning what I fear will be a lengthy paper let me first say that but few are the original remarks, and but commonplace most of the theories, and that I claim no special knowledge and anxiously await criticism and enlightenment in a humble and enquiring spirit.

General considerations.—It were well to take, if time permits, the progress of a laparotomy, then to digress on to special conditions and finally to conclude with complications and their diagnosis as far as in me lies.

Considerations of time limit me strictly to the conditions arising after the cessation of the anæsthetic, and the story opens with the patient on the operating table with the abdomen closed and stitched, a tight dressing and binder applied, *the skin everywhere well wrapped up*, on the point of being borne away on a trolly to the adjoining bed. And here I should like to say that an ordinary jack-towel secured by stout steel pins and Spen er-Wells forceps is an excellent abdominal bandage for the first forty-eight hours, but that beyond that period it neither suits the patient, his skin, or his temper, nor is it as efficient as a properly adjusted domet many-tailed bandage, except for the rotund, "obese, untrammelled," corporations of elderly women.

Vomiting will occur, especially if the patient is young and previously healthy, but often *not* if he or she be acutely ill, emaciated, cachetic or thoroughly septic, nor if the operation be very severe and prolonged. Of the suppurative peritonitis, four in number, and the two intussusceptions I have anæsthetised, none suffered from more than single sickness, and the longest anæsthetic I remember—three hours and forty-five minutes—the patient vomited *only once* within ten minutes of the cessation, and went home within a fortnight.

The causes of vomiting, their recognition and treatment.—It seems to me that there are three main classes of vomiting, and that by careful observation they can be distinguished, and as the treatment varies it is well to attempt their discrimination. The three main varieties are:—

Primary vomiting, that which lasts from the end of the operation, say 4 p.m. to 10 p.m. roughly, the first six hours, and may still be a cause up to twelve hours.

Secondary, which begins three to six hours after the operation, is often the sole cause up to twenty hours, and

Late vomiting, which is a reflex vomiting occurring as the result of the some complication.

The cause of *primary vomiting, i.e.*, that which occurs immediately after anæsthetic up to about six to eight hours, is the direct irritation of the vomiting centre, lungs and stomach, and of the poisoning of the nerve centres in the brain—comparable to alcoholic vomiting in the early morning and to vomiting after gas and oxygen, and to the sickness of syncope. It is as a rule transient and negligible, it is the chief cause in chloroform anæsthesia and in patients who do not secrete much

mucus, and it occurs less in proportion to careful preparation before the operation.

The cause of *secondary vomiting* is the irritation of the gastric mucous membrane by the presence of a quantity of anæsthetic vapour, the effete products of the destruction of the anæsthetic vapour and of the saliva and mucus swallowed during the operation, especially in tuberculous patients, who always, even in the absence of active mischief, secrete much mucus. The vomit is usually green, acrid and acid in reaction, and though described as bile-stained does not always contain bile.

The cause of *late*, as distinct from simply delayed vomiting, is peritoneal irritation of any kind or reflex vomiting from whatever cause, and in the diagnosis of its causation lies much difficulty. In acute peritonitis it occurs from the start. In point of time it may arise from about twelve hours to twenty-eight hours afterwards, or any time in the first four days. It may be due to reflex distension, flatulent dyspepsia, constipation, obstruction, and peritonitis or abscess, to mention the most common causes. I will refer to the diagnosis later on.

The treatment of *primary* vomiting is rest of mind, body and stomach, therefore give morphia if required for pain of either mind or body, and give no fluids by mouth for rest of stomach, in other words, use rest and do nothing except wash the mouth.

The treatment of secondary vomiting is to remove the cause, the decomposing contents, and to assuage the gastric catarrh. Two methods are available: —

1. Return of the swallowed contents by the œsophagus.
2. Expulsion into the duodenum.

It is obviously better to recover the foul matter, and as a matter of fact the second course does not occur. I leave it to the physiologist to explain the undeniable clinical fact that acrid and acid fluid contents may be in the stomach for hours and the pyloric sphincter not relax to allow their passage, even when the stomach is contracting. An effort of will sometimos represses the vomiting and passes it on, but this is unusual.

Methods of evacuating the stomach by the œsophagus.— Firstly the unfailing method of a stomach tube, which may be done on the table or in bed while unconscious. It has been done with great success. I have not seen it done but should be quite ready to try it if necessary, which I do not think it is usually.

The "soda-water trick," which has never yet failed in true secondary vomiting.

It is this. Usually on the night round, some six to eight hours after, you will find the patient has got uncomfortable and often just beginning to be sick while conscious. Fill a feeder quite full with strongly effervescing soda, with two drachms of sodium bicarb. dissolved in it, and get the whole amount swallowed without delay beyond that necessary to breathe. Encourage her to allow wind to rise, and if in two to five minutes it has not returned give another feed. The result will be an easy evacuation of the stomach, with manual support of the incision.

If the vomit is frothy, green and unpleasant repeat the dose again and again till the vomit returns clear, usually at the second attempt, and then leave morphia to be given if the patient does not sleep within the hour. They usually do after vomiting, the relief is so great.

The point is to distend the stomach well and to clear it out.

I am convinced that the earlier and more copious the unconscious vomiting is the less the subsequent distress.

Thus the treatment should be, to hope for a good vomit on return to bed, then to leave the stomach for four to six hours for the effect of rest, and then to remove any acid stomach contents by soda water and bicarbonate of soda.

In this connection the remarks of Sir Frederick Treves I find entirely bear out my own convictions that the absolute starvation or limitation of drinks and rectal feeding system is cruel, unnecessary, and baneful; his words, speaking of giving liquids are :—

"This little indulgence does not introduce anew the symptom of vomiting. It is there but it is latent and the drop of cold water only makes it evident. If a rigid system of exclusion of all fluid renders the symptom latent, it does not abolish it."

When one reflects of the agonies of thirst some patients are condemned to, or were, the above clear statement renders, I hope, the practice impossible.

If a patient has *not* vomited by four to six hours, except in rare healthy adults to whom a dose of alcoholic gases is but an incident in a well ordered economy, I believe vomiting to be inevitable though it may be postponed some four, seven, or twenty-four hours by starvation or by infinitesimal doses of hot water. *Ice* should *never* be given (although there is no objection to "icing the drinks" and also no advantage). Hot water is as comfortable, and the flatulence caused by ice is one that the patients do not readily forget, if they undergo two operations and note the difference. The pain and shock of dry retching is most intense.

Actual gastric lavage I gave an extensive trial to in Queen. It answers well, but the patients do *not* like it. Some do, and the effect of a carefully passed tube is not necessarily unpleasant. However, except in bad cases, the large drink is as satisfactory and more acceptable.

I washed out without discomfort the stomach of a patient who was dying of peritonitis and septic toxæmia eight hours before death. The uncontrollable vomiting and nausea which is so typical of this fatal condition never recurred, and she was extremely grateful for the relief. I have not seen sufficient cases of peritonitis to know if this is often the case, though Treves says it is the only useful treatment (a high authority on such matters).

The treatment by ice, oxalate of cerium, tincture of iodine, bismuthi et morphinæ, et hoc genus omne, I take to be unsound and empirical and therefore untrustworthy, and only to be used in that unhappy and bewildering state of mind that requires to be "doing something" after the regular treatments have failed. The only patient I saw energetically treated with all the above

and more, died on the fourth day from unsuspected intestinal obstruction.

Champagne, iced or not, is perhaps worthy of a place among sound treatments. It contains a good safe stimulant with the carbon dioxide, but it brings an irritating fluid to the gastric surface, and it is quite distressing to see patients pathetically complain that a brandy-and-soda or a glass of champage has not brought the accustomed comfort and joy that it does in times of health, owing to its irritating the mucous membrane.

CO_2 and warm saline have a most soothing effect on acute gastritis, and nowhere is it more shown than by the treatment of acute gastritic catarrh caused by foul acid mucus.

Another point is that vomiting lasting over eighteen to thirty hours is almost invariably the direct result of peripheral nerve irritation, acting on the vomiting centre, probably through the medium of the sympathetics, and means peritonism or peritoneal irritation if not peritonitis. It is rare for the vomiting due to foul stomach contents to persist so long in the absence of atonic dilatation. It must be borne in mind that peritonitis is not necessarily fatal nor suppurative.

In this connection vomiting due to peritoneal irritation must be distinguished from that which comes on after improper and too early feeding, and also from delayed vomiting which comes on sixteen to eighteen hours after operation which has been postponed owing to the careful way the stomach has been left at absolute rest, a process which only postpones the inevitable vomiting to a later and more distressing period in the vast number of abdominal patients. There is this to be said, that morphia often acts to stop vomiting partly by its rapid, local, sedative action on the coats of the stomach and the afferent nerve fibres, partly by the quiet frame of mind but chiefly by the depression of function that follows on its administration.

To sum up, one or two vomits in the first four to fourteen hours is physiological and usually inevitable, though the amount of vomiting, ceteris parilus, varies immensely with the skill of the anæsthetist. The more uniform the anæsthesia, and the better it is given, the less the vomiting. I have noticed both in my own and others, cases that as the administrator became more expert, the vomiting after operation became often less troublesome.

Vomiting for sixteen to twenty-four hours is unusual and is often avoidable, and in the absence of peritonitis or reflex irritation, such as a gauze plug on the diaphragm is due to decomposition of mucus and acid fermentation, and is best treated by copious draughts of saline or soda-water, or a severe case is usually relieved rapidly and completely by lavage.

Vomiting from thirty to forty-eight hours usually means peritonitis, obstruction, or some such form of peritoneal inflammation, and is considered later on under complications. In general I do not expect a normal patient to vomit after ten next morning at latest, and six to eight hours is not an unusual term if the "soda-water trick," as I have heard it called, is properly tried.

To return to the patient after this digression into the causes of vomiting. The patient on return to bed should be warm, hands and feet, quiet pulse under 90, full and good, not sweating, temperature normal and not below 97·8°, but if collapsed or feeble the bed should be raised at the foot. She should excrete in the next twelve hours about sixteen ounces of urine, maintain at least a temperature of 98·4° and upwards, not suffer from pain, flatulence, or violent vomiting, but may be expected to have some headache and thirst, though the latter should *not* be a very prominent feature. Her face should be free from pain and her mind placid. In the absence of hæmorrhage pulses in Bright in well ordered operation even of an hour and a half often do not exceed ninety. Taking the commonest deviation from the normal, "shock and collapse" due to a prolonged and severe operation, it will be well here to define and discuss "shock and collapse" and to outline the treatment.

Shock "is a state of great depresion of the vital activity into which a patient passes as the result of sudden, severe and prolonged irritation of the peripheral nerves, especially of the sympathetics" (Treves).

Collapse, which usually is accompanied by shock, is more a condition of exhaustion of nature due to reactive forces wearing out, as evidenced by the increased action of the heart, the muscular relaxation, and the cold, flabby condition and the increased specific gravity of the blood. Thus hæmorrhage up to a certain point produces no collapse as the restoration of serum from the tissues has compensated the loss.

Collapse only comes on after failure of the tissues to supply more serum. Shock in set operations with modern conditions is rarely severe or fatal, and as the measures taken to combat the collapse are usually successful, the condition of shock gradually disappears. There is no treatment for shock, but several for the allied and contributory collapse.

Shock is sudden usually and essentially a state of inhibition of nerve fibres and of reflex paralysis of the vasomotor centres in the medulla oblongata. The amount therefore varies with the severity of the irritation and the length of time of its action. The circulatory balance is upset, the abdominal veins become overfilled, the arteries are empty, the lungs and heart suffer, the brain is anæmic and eventually the heart stops. Pain, fear and shock are similar conditions. The papillary, respiratory, voluntary motor cardo-muscular nutritive and physical phenomena are identical. To enumerate them briefly they are—

Pallor of skin and mucous membranes.

In pure shock the specific gravity of the blood is unaltered, but the tension is low.

Loss of facial expression and muscular relaxation.

Eyes dull, pupils dilated, slowly reacting to light (this is apart from anæsthesia).

Cold profuse perspiration.

Feeble, irregular heart action and sighing respiration.

Diminished sensibility, and

Subnormal temperature, with cold surfaces, a most important point and most easy to verify.

With regard to the latter point, it has been said by an eminent authority, Rogerson Fowler, that improvement should be expected in a few hours, and that if the temperature is but one degree (97·4°) below normal recovery will occur. If three or more (below 95·4°) it will not. With this I entirely agree. A subnormal temperature is infinitely more ominous than pyrexia after abdominal section.

This condition requires to be distinguished from hæmorrhage and embolism. The history of a trained observer will do this, failing that cross examination and common sense will help much. The pulse is almost a useful aid; a very rapid, regular, splashing pulse, with warm limbs in a patient otherwise normal, is diagnostic of hæmorrhage or loss of serum, and the specific gravity of the blood in a doubtful case will help. Also a blood count, but of these I have but others' knowledge to relate, and I hope the authors of some useful observations on this point will contribute them to-night. Mr. Wilkin has done some excellent work on these conditions and points out that the differential diagnosis by means of the specific gravity is easy, if observation has been made before and after operation.

The prevention of shock hardly comes into the scope, but briefly I do not believe strychnine, caffeine, or brandy help at all, though I recognise that stimulants after shock are of little avail in bad cases. With continuous warmth of the patient, fluid feeding till late (up to three hours or even *two* hours previously), and with rapidity of operation and careful organisation I have not a quarrel, but the highest praise.

Ingenious but futile is the tourniquet method of storing up blood in the extremities to be released when required. Dr. Beddard, Leonard Hill, and Collett's experiences on shock and collapse have so completely settled the question of the causation and treatment that little discussion remains. In shock, the abdominal veins would easily accommodate the entire fluids of the body without raising the venous pressure appreciably.

The treatment of shock is that of the allied conditions and is not, as far as I have seen it, varied or difficult. Strychnine in large doses, lowering of the head and warmth are the best, and if they do not answer it is unlikely that others will. Infusion, as a matter of fact, will probably benefit, as pure shock lasting long without collapse is a very rare condition, though care must be taken not to embarrass the circulation that way.

Roger has given a convincing reason why drugs and stimulants are not useful, though I believe that clinical evidence rightly upholds strychnine.

In frogs in whom a Leyden jar discharge had affected the frogs so as to produce profound shock, the spinal cord and muscles were observed to be irresponsive to strychnine and veratrine respectively, and as these substances were circulating in the blood it was *not* due to failure of absorption but to failure to stimulate.

The action of stimulants of all kinds is discussed elsewhere; probably except for shock and great emergencies their effect as stimulants is bad.

The most strychnine I have ever seen given was 45 minims in twenty hours, and 380 minims in fourteen days, and to my mind the patient would have done equally well without any after the first twelve hours; that is, stimulants are only indicated as a temporary measure, if the shock is long they are better saved till inevitable.

The feeding of abdominal sections.—There are several points to be borne in mind. That a healthy adult can stand well and with benefit starvation for twenty-four hours *provided the supply of fluids is not curtailed*, and that too early feeding will bring flatulence, dyspepsia, and vomiting in its train. But, on the other, hand it is quite possible to kill a patient by starvation and exclusion of liquid, and that within two days, as a familiar case recently showed in Clinical.

The stomach for the first twelve to twenty-four hours is too much upset to allow of much feeding as a rule, while it is perfectly possible to feed a patient per rectum for a week without great difficulty provided the rectum is washed out periodically and care taken over the administration.

A few years ago the invariable practice after a long or severe operation was to give a coffee enema, a port wine enema, or a nutrient enema with brandy in it, and in abdominal cases to give one six-ounce nutrient every eight hours alternately, with one nutrient suppository made of some meat preparation. Dr. Beddard in his paper demolished all that practice, and as a physiologist and clinician has set our knowledge on a sounder basis,

Alcohol, whether as port wine or brandy, is but a stimulant and in the rectum also an irritant, and has for both reasons to be condemned; the same applies to caffeine, but not to strychnine, a most valuable post-operative stimulant in "collapse," while a rapid running pulse with good colour, restlessness, thirst, good tone and general healthy appearance, means as a rule a need for fluid, and it is best supplied by normal saline, one drachm to a pint. A pint is always retained I believe *if slowly and properly administered* immediately after the patient is settled in bed, and is a wise precaution in all cases lasting over an hour, as it obviates thirst and subsequent discomfort. The rule I go by in Bright in all operations lasting an hour, all operations involving hæmorrhage, and whenever the pulse is over 105. Arbitrary but fairly satisfactory guides. Intravenous and subcutaneous salines should be ʒis. to pint.

The rectum will readily tolerate Oi. of saline every six hours; or nearly Oi. four hourly if there is great need. Nutrients must not be so bulky, Os. is the maximum. As a rule, intolerance of enemata indicates the cessation of their necessity. Another method is to give half-pints of

nutrients made of peptonised milk or a solution of sugar every six hours, or ʒvi. every four hours.

I believe with a pulse under 90 and no thirst nutrients are not required unless vomiting lasts over twenty hours. Give Oj. every six hours of saline, or Oss. of peptonised milk is best.

I can speak well of the sugar method, but the solution should be diluted not more than a one ·5 per cent. solution, but I am not in a position to dogmatise about it yet, though convinced of its efficacy.

Other methods *are* hypodermic infusion of three pints, or intravenous infusion.

The method that gives good results is to allow only washing of the mouth with drachm doses of hot water from six to eight hours, then if sickness is inevitable to use the soda trick. Get them to sleep and start ʒiij. ʒij. feeds at eight next morning, allowing a cup of tea early. Unless vomiting last beyond eight, or there has been loss of fluids and thirst, there is no necessity for nutrients.

A pulse of eighty and under with a pint in the rectum after the operation little thirst is ever complained of.

Thirst is of course an absolute indication for saline per rectum.

A description of the technique of either methods is unnecessary, but neither with a properly constructed apparatus and needle ought to take more than ten minutes to perform.

For venous infusion the best method I have found is to cut freely down at the bend of the elbow over the media cephalic or basilic, and expose the vein. This is not difficult and a bandage or compression is not required in practised hands. Free incision and a careful survey of the part is all that is required to find the vein crossing the occipital fascia. Only a tiro and a crock will injure the artery.

When the vein is exposed it can be quickly and easily infused by simply pushing in the point of a large hypodermic needle, but as a rule a cannula is better. Hydrostatic pressure is better and more reliable, as the need for force indicates that something is wrong with the vein selected, or with the method and force is not a good way of overcoming the obstacle.

There is but *one* indication nowadays for intravenous infusion as opposed to hypodermocylsis or rectal salines, and that is the *instant necessity* of restoring the vascular tension to avoid fatal syncope, that is such an urgent condition of collapse and anæmia that the delay of a rectal injection will prove fatal.

In all other cases the rectum is to be put first and the hypodermic method next. The indications for instilling saline into the rectum or tissues are—

(1). After a long operation, without loss of blood. The experiments of Collett and others show that the specific gravity of the blood is maintained by abstraction of an equivalent amount of fluid from the tissues, and fluid is needed to replace this when the tissues can no longer yield more without difficulty. Experimentally this is about a three-quarter hours anæsthesia. If there has been much hæmorrhage, and, if the pulse is rapid, over 110 and rising, the face is pinched and the skin dry and cold, with great thirst and restlessness. Three pints hypodermically, or a pint per rectum every four hours of normal saline, will relieve.

An excellent test of the efficacy is the slowing of the pulse, the secretion of urine and sweat, the first being a good indication of the effect of the infusion and of the need for more of its uses again. The second a good prognostic sign of re-establishment of the normal blood-pressure, and the third is not of much value. In addition to this, later will be noticed the soft moistening of the tongue, the absence of thirst, and a valuable sign the filling out of masseter region (Steward), and the amount of urine secreted. If the pulse again rises and no other cause, such as peritonitis, is present, nor considerable shock, it should be repeated as often as required. Only what is required is taken up, and the rapidity with which three pints will be absorbed after a long obstetric operation, is marvellous when the need is great. But after a large hæmorrhage, such as a gastric ulcer, or placenta prævia, infusion beneath the skin is not indicated till the hæmorrhage has ceased. Otherwise the rise of blood-pressure may restart the condition and death result as the result. In a grave hæmorrhage do not infuse, but operate. No condition is so grave that a well given anæsthetic will *hasten* the end, and the bleeding is so often continuous that the increase of pressure, though restoring temporarily the pulse, as in shock, only really increases the hæmorrhage and the danger. No surgeon or anæsthetist ought to fear a case like this, and no anæsthetic well given (and there is a factor of enormous often unconsidered value in the experience and skill of the anæsthetist); no anæsthetic properly given, I fearlessly assert, will *hasten* the end in the cases.

Under the proviso "properly given" I most decidedly include the question of the anæsthetic, the method, and all else. Gas increases the tension, and has no advantage but speed. In peritonitis without vomiting, in acute sepsis, it answers well if rapidly followed. *Ether*, the most favoured, is radically wrong in hæmorrhage. The bleeding is increased, the heart is enormously stimulated, and struggling is more likely. The ideal anæsthetic is A.C E., or kelene followed by A.C.E., given slowly and pressed slowly to deep anæsthesia and then relaxed to just short of movement. The indication is to avoid stimulation and avoid struggling and make the operator and assistant waste not a second. In well organised wards arrangements ought to be nearly twice as quick as in Clinical in cases of need. In shock, in peritonitis, the length of the operation and the amount of exposure varies inversely with the prognosis. I am quite sure I have seen intussusception and generalised peritonitis saved by rapidity and efficiency of the preparations. Another point is, do not give too much. Hardly any A.C.E. and air will keep a serious case from movement, and the shock (pace many experts—yet see Treves) does not depend on the anæsthesia (Watson Cheyne says: I cannot accept the dictum that complete anæsthesia protects

from shock). No one has even succeeded in depressing the last reflexes by anæsthetics without fatal results: *life itself; respiration* and *heart-beats*; being but reflex actions under reflex control.

The indications in hæmorrhage from any intraperitoneal cause are first to secure the bleeding point or points, not to do too much, to venifuse only if urgently required, and for present danger to infuse hypodermically, and by rectum repeatedly, to elevate the foot of the bed, perform auto-infusion, and to stimulate by stimulants as required. In collapse from long operation fluid by rectum and skin is urgently indicated, and most cases are benefited by fluid by the rectum, the skin, and the veins in the order of merit and simplicity.

The effect of each differs; the rectum absorbs but slowly, the tissues quickly, and the veins quickest, but the excretion from the blood is equally rapid in the latter case, and not so lasting as the subcutaneous method.

In shock, in exhaustion, and collapse on the second day from simple weak vitality, or with diarrhœa and vomiting serum, anti-streptococcic or sheep's, subcutaneously answers very well; and sugar, a ·5 per cent. solution of dextrose answers admirably. An old lady of 82, whose malignant fundus was admirably removed by laparotomy, about the end of the second day began to get feeble, cold in hands and feet up to and above the knees, in spite of hot bottles and strychnine. The late sister Queen, Miss Cottor, no mean observer, thought she was moribund, but a pint and a half of sugar solution, subcutaneously, in half an hour restored her vitality wonderfully, and she eventually lived. I believe in this case the sugar solution saved her life, after foods, salines, and enemata, etc, had apparently failed

To return to feeding.—The situation being that healthy people can stand starvation, that exhausted patients require fluid and strychnine, it is well not to give any *food* by mouth nor by rectum till four to eight o'clock next morning as a general rule—this is ten to twelve hours after. Three hours after allow drachm feeds of hot water and soda, and give soda for vomiting. If the vomiting has subsided, begin at six, or eight, or ten next morning, according as the sickness goes, with ʒiii. of hot water and give ʒij. two hourly, then gradually increase this to ʒ iij. to ʒv. every two hours and then to every four, substituting for hot water an equivalent amount of any of the following:—

Albumen water.
Barley, or
Soda and milk } Equal parts.
Soda alone }
Milk.
Bovril.
Beef tea.
Valertine.
Rum and milk.
Whisky and milk.
And most important, tea or coffee.

A cup of tea is always allowed and often answers well next morning; it often restarts peristalsis and is much appreciated. Do not give peptonised milk nor patent foods; the peptonised milk is horrible and makes them sick, and presents no advantage. If the stomach cannot digest milk and soda, better wait till it can.

The second morning give custard, bread and butter, bread and milk, cautiously waiting until the appetite demands more. Give medicine the third morning or second night, and the food question after that is simplicity itself. Meat and vegetables they will not take well before five or six days, except chicken.

The above routine can be varied. The absence of sickness, or excessive appetite, or exceptional vigour, demands relaxation.

Two patients have eaten hearty suppers after an hour's anæsthesia, but they are rare, and never abdominal cases, and they suffered from indigestion afterwards.

Whisky and soda, and brandy, and champagne may pull a patient together after an anæsthetic. To the alcoholic give alcohol and soda, and suspect women in that way. More women ask for brandy and relish it than men in my experience, especially to one's horror, the young and innocent-looking chronic home invalid.

The keynote of feeding is to get rid of the vomiting early, give twelve hours' rest at least, start slowly and let the *feeds wait on appetite and digestion will wait on both*, and simplicity is above all other things the keynote. Eggs are not well too early. After vomiting recurs give four hours' further trial to ʒi. feeds of hot water, unless the vomiting is obviously due to mucous and gastric catarrh, when soda water, repeated if necessary, is desirable, and then two to four hours' physiological rest.

I tried the Oss. of strong soda on several patients; once cures about half; a repetition of Oss. directly after the first cures a quarter; and three vomits I have only once seen, and it stopped at once after that; but it is well to give the stomach rest after the process.

Constipation.—No two cases are relieved alike, and no rules can be given. Personally I believe in a purgative enema of castor oil, turpentine and soap to be most refreshing, preceded by mag. sulph. effervescens, but in the absence of discomfort, distension, flatulence or dyspepsia, do not worry about the bowels. An unfailing method is a grain of calomel every hour up to ten grains which at the latest will act next day, and a *smart* purge to my mind spells ʒss. pulv. salium. with ten minims of nux vomica. Often when salines fail a drachm only of senna and sulphur answers like a charm. Rectal feeding often causes vomiting to recur and it is heartily disliked by the patients—a point to bear in mind.

Fortunately, diarrhœa and sickness together are very rare, and usually mean some complication. If the bowels are irritable, cocaine or opium or tannic acid may be tried, but usually the stomach is by then tolerating feeds. Constipation and vomiting go together as a rule, and relief of the one often cures the other.

Turpentine enemata are frequently retained, therefore if given with starch, omit the starch if in doubt and give

castor oil as well, and pass a long tube if necessary. Although no evil result usually follows from the retention of turpentine, still it is a sign of grave import that the intestine does not respond.

Abnormalities and incidents in first forty-eight hours.

Headache.—Present in about 70 per cent., absent in alcoholics often, and certainly varying inversely with deepness of anæsthesia and the want of oxygen; patients who are blue suffer more from headache. It is best treated by cold spirit lotion, eau-de-cologne, a small dose of (℥ii.–℥iii.) mag. sulph. effervescens with ten grains of phenazone. It is usually lost sight of and does not keep people awake. It is more intense if proper purgation has been omitted.

Retention.—In male abdominal cases this is not common unless the bladder has been manipulated or the bandages and posture are such as to offer a mechanical difficulty. Practically the only remedy is a clean soft catheter (6–8), lubricated well with either boiled oil or sterilized vaseline. Cystitis practically never follows, unless a rough, dirty, or forcible catheterisation is performed.

In women the routine is to pass a catheter at 4 to 6 a.m. if they cannot pass it earlier. In gynæcological operations this is usually required. It may lead to cystitis which *always*, I believe, yields rapidly to urotropine gr. v. to x. 4tis. horis. Dr. Pitt, Dr. Galabin, and Hurry Fenwick, believe the smaller dose to be the maximum required or safe. I have *not* seen harm but much good from the larger dose. Ten to sixteen ounces is within the limits after a long abdominal operation, and is usually a mass of urates, but quite acid and free from mucus, pus, or albumen. It is often required twice, rarely more; once is the average in all abdominals.

Scanty urine is due to low blood-pressure and is a valuable indication of want of fluid and feeble reaction, and the converse is also true.

Suppression.—This is rare in the absence of such primary causes as—

Removal of only kidney.
Ligature of ureter of only kidney.
Dislodgment of stone or clot into only ureter.
Ligature of both ureters (in hysterectomies).
Shock of abdominal irritation in a chronic Bright, etc.

Treatment.—Hot packs. Hot drinks, copious. Cupping. In vaginal hysterectomies, inclusion of the ureter in the clamps requires early removal of clamps, and will give rise to ureteric fistula and probable recovery.

Hiccough is a most distressing and rare condition. Treves calls it a very grave symptom. It is due to irritation of vagus nerve endings, often by the direct affection of the diaphragm by pus. The authorities find that its presence is sinister, but I have more often seen recovery than not. Distension of the stomach or carminatives alike may help, but I know no direct treatment. It is an indication of peritonism or reflex irritation.

Flatulence.—It may arise in the stomach, small intestine or large. With the cessation of gastritis and quiescence of the stomach, stomach wind usually ceases to worry, though rolling over patients on to their side carefully and propping them up, often gives great relief. It will be relieved by any of the following in order of merit. Tinct. carminativa ♏x., essen. menth. pip. ♏ij., creasote ♏i., tinct. card. co. ℥ss., and tinct. nucis vom. ♏i., o.h. Small intestinal flatulence is more difficult. Two minims of ess. menth. pip., and two drachms of mag. sulp. effervescens, or half-an-ounce of mist. alba. are the most reliable, and to my mind best. Calomel or salol also do well. Large colic distension is due to the decomposition, and is most easily relieved by a long tube, which, however, needs care, as several peritoneæ have been wounded by its use with fatal results. A turpentine enema also is unfailing in its relief. My own preference is for mag. sulph. and peppermint, and either a tube or an enema, and sal. volatile or ginger.

Flatulence is to be distinguished from paralytic or reflex distension.

I have seen a woman who "cribbed" and by persistent swallowing distended her stomach enormously with wind and embarrassed her heart. This rare neurosis was unrestrainable, and she eventually died from exhaustion and lung troubles, in a great measure also as the result of great distension.

Pain.—Real pain is not a necessary result of a laparotomy. It is an indication usually of not defective but not ideal surgery. It may mean parietal inflammation through rough handling, too tight ligatures, flatulent intestines, obstruction or some avoidable incident. Uneasiness, discomfort, soreness, consciousness of the incision, but not pain, is the rule, and morphia is rarely required for this alone, though perhaps it is well to give it.

Here may perhaps be briefly considered the question of hypnotics and a few dogmatic remarks are put forward for criticism: –

The less morphia the better, and none is best.
The better the result the less need for morphia.

Flatulence and morphia often go hand in hand and morphia sleep is often interrupted by vomiting, by colic, and followed by headache. But the mental and moral effect is good, it eases pain and promotes *rest*, and rest means repair. I never *refuse* $\frac{1}{6}$ or $\frac{1}{4}$ morphia after an operation except for suppurative peritonitis, when if there is proper drainage strychnine answers as well, and to which morphia may often be well added, but I hardly consider this "giving morphia," and it does not cause constipation.

Morphia is not always required. To my mind the need for morphia means, either the patient is flatulent from improper preparation, or vomiting unduly from unsuitable treatment, or else the operation has involved unusual damage to the peritoneum. Apparent pain may often be alleviated by other means, though if there is actual pain, morphia *alone* (without atropine) I believe to be the only treatment. Sedatives, hypnotics, like Pot. Brom. are useless in the presence of real pain, and if pain is not present sleep can be better induced by other methods. Morphia without atropine causes less dryness

of the mouth, and the effect on the bowel is negligible. The question of pain and *sleeplessness* are so involved it were well to consider them together.

If pain is the sole cause of want of sleep, morphia ($\frac{1}{4}-\frac{1}{3}$) is the only treatment. If pain is due to some minor trouble, search will often reveal it, and removal of the causes will bring sleep. Pain in the back most abdominal patients complain of. It is, perhaps, in part due to the extended position or the exaggeration of the lumbar curve that occurs in the supine position on a flat surface. It is partly corrected by raising the head and shoulders, and by raising the legs and flexing the thighs, but is usually a reminder of the position on the operating table. It is due then partly to the position on the operating table, partly to the position in bed, and more still to the reflex effect of the irritation of the ligatures, and cut nerve endings, as it is common in most, but invariable in all gynæcological operations. It is best and most successfully treated by a "tommy," a soft stuffed pillow inserted to fill the gap. The hand passed just above the sacrum detects an arch (the lumbar curve). Fill this and the counter-pressure will rest the muscles and relieve the pain. Hot bottles will do the same with greater difficulty and trouble. It is a most invariable complaint and one usually most easily remedied.

Pain is also due to retention, an often overlooked cause, as in a patient of mine, who after abdominal section passed twenty-eight ounces of concentrated urine in eighteen hours, leaving a residual urine of a pint and a half still left due to chronic bladder atony following chronic dilatation and cystitis.

Pain is also due to colic of intestines and is relieved by hot applications, and the worst cases by morphia or belladonna or both. In the epigastrium it usually means colic distension, and often flatulent dyspepsia, and may be relieved by carminatives, sleep often following quickly after.

The tendency is strongly to sleep and sleeplessness in the absence of drug habits, must after laparotomies have some direct cause.

A patient in Bright was accused by me of taking drugs as she suffered so from insomnia, in spite of careful consideration of any other possible cause, and though indignant and fulsome in denial, eventually admitted Indian hemp.

A change of position will assist *some*, but it rarely answers to shift laparotomies on to the side. Care must be taken that pleuritic rubs due to chronic or concealed phthisis, arising rapidly and insidiously, is not mistaken for abnormal pain. It may be due to the diaphragm being involved which often gives rise to pain localised strictly to the epigastrium.

Rigors which occur early after return to bed, small, frequent, and not severe, are due to the anæsthetic, especially to ether, and may occur on the table. Pathology can only be surmised and the treatment as uncertain as it is unnecessary beyond promoting warmth, which is always an indication.

Other *abnormalities* of mild type are oozing of blood and pus requiring drainage and dressing. This is not painful and only rarely required after laparotomies, but the dressing of a wound the night after operation for hæmorrhage and the re-appliance of the bandage after is so comfortable, that sleep, but little denied, often ensues.

Coming now to abnormalities of *later stages* and more or less serious, but not requiring as a rule the summoning of the operator and friends we come to—

Suppuration and stitch-sinus, septicæmia, thrombosis, embolism, hernia, and escape of intestines, cystitis, rigors —but here I do not include peritonitis or other septic conditions, nor such accidents as obstruction.

Suppuration and stitch-sinus.—Suppuration of the abdominal wall is rare and ought not to occur. It is the result of defective surgery invariably and constitutes an avoidable source of failure, but is likely to be always present in a small percentage. Do not believe in auto-infection, but wash your hands in lysol and practice asepsis.

Stitch-sinus depends on the operator, the patient, and the stitch.

Tightness of the ligature is only important in respect of the degree of infection the stitch obtains from the operator's finger in the tying process. Of itself it means nothing.

Most ligatures, nowadays, are tied tighter than necessary. A double nought silk will hold quite large vessels when carefully tied.

Ligatures.—It is not my intention to air any views on this point, but to note a few facts. Salmon-gut does not absorb, but usually remains sterile. Silk or cat-gut is usually buried, either answer perfectly if *sterilised* (a perfectly possible process, but one that requires care), but no finger must be used to the silk, but only instruments, the only proper method of putting in a buried suture. Deep salmon-guts through the whole thickness of the wall never give rise to trouble (why it is, is hard to say), as the author once saw on the sixth day in a hæmorrhage case suddenly fatal, the salmon-gut quite free in the peritoneal cavity, through which the more or less septic end of the gut must shortly have been dragged in the process of removal, and yet peritonitis never ensues on stitch removal. Sinuses are often extremely intractable, and always contain some irritant such as a *stitch*, in my experience, but after removal, the cautery, sulphur or such a strong antiseptic as hyd. perchlor. may effect a rapid cure.

Temperature.—A rise for three days and the fall on the opening of the bowel is common, and quite safe. A rising pulse and a rising temperature, with good general condition and a placid facies, is not serious. It may be the anæsthetic, or absorption of blood, but the facies abdominalis with a rising pulse, a cold skin and a rectal temperature, is an evil omen.

Mr. Symonds speaking of falls in temperature, says: "I might give many examples to illustrate this pregnant fact, that temperature and pulse may steadily fall, while dangerous septic processes are steadily advancing."

Mr. John Malcolm, in a most instructive monograph, has written so much, that it is difficult to quote, but he notes that the arrangement of the intestines is often a serious matter, and that saline lavage is one of the best methods of getting them stowed properly.

To my mind the most important thing is the impression one gains by observing the patient's appearance, and his view of life. These are more faithfully indices of safety and progress than any other symptom.

Embolism is nowadays rare. Dr. Galabin tells me he used to lose patients after hysterectomies formerly, but rarely latterly. It is sudden and inexplicable, but if the patient survives to be seen is usually recoverable. The symptoms are sudden *acute pain* over the sternum, possibly hæmoptisis, pallor, syncope, dyspnœa and death. It is due to acute dilatation of the right ventricle, and should be treated by "venesection" if seen in time and ether injections, the most diffusible and active stimulant, but the remedy must be prompt as five minutes settles the attack one way or the other, the fatality naturally depending on the size of the embolus.

Thrombosis is not uncommon. I believe it to be septic, associated with constipation and a result of cachexia, as it is rare in robust patients.

Cystitis and incontinence is the result of injury due to catheters, to imperfect emptying, and last and least to imperfect antisepsis, in the order mentioned. Taken early it rarely is troublesome, and taken late is best treated by cystic lavage with boric acid and by an antiseptic, self-retaining catheter or male catheter, pace, several distinguished surgeons. In men it is rare.

Here I might add a word on the opposite condition. *Retention* occurring late due to atony of the bladder and incontinence of urine due to overflow. *Both* yield rapidly to a catheter, tied in the male (in whom incontinence is rare), and to a self-retaining hard catheter in a female left for thirty hours, and for the same reason both are due to overstrain on the bladder walls which regain their muscular tone by the rest they obtain by this means. In hospitals and homes and properly nursed private cases there is, I believe nowadays, no risk of bladder infection.

We now turn to the events of the second night and second day when diagnosis of progress or of impending disaster is all important.

The onset of peritonitis.—The most likely malign complication is peritonitis and the mistake most easily made is to miss the distinction, often being one of great difficulty, between intestinal obstruction, peritonism, peritonitis, and reflex or paralytic distension.

Let me briefly remind you of the present state of our knowledge. Sepsis may be introduced in two main ways. It may be rapid, acute and fatal in forty-eight hours from a virulent acute infection by the operator, including for sake of brevity under this head his hands, his sweat, his instruments, his sponges, his ligatures and the operations of his assistants and nurses. Such things are luckily rare; they are never practically due to ligatures, sponges, or instruments; if even *ordinary* care is used the infection will not be very acute, and although I know the failure has been attributed to the sponges I have never seen it myself established as the only cause.

The most frequent cause of acute general toxic peritonitis rapidly proving fatal in from twelve to thirty-six hours is very often the unsuspected or ignored presence of a "torment" or a "hang-nail" by the side of the nails of the thumb, first or second finger. After this the soiling of the peritoneum by fluid of a dermoid or an ovarian cyst, which is often intensely irritating, in which case death may be as much due to severe shock and invasion through the intestine of "bacillus coli communis" as to acute peritonitis. Contrary to the general impression, forehead perspiration is practically harmless, especially if it has been mixed with hyd. perchlor. beforehand. The reason for this is that pathogenic organisms are not common on the face and are but staphylococcal in general and not of a high virulence.

Up to a certain degree of concentration and dose, the peritoneum can and will absorb any poison, but if the virulence exceeds a certain unstandardised limit reaction and not absorption takes place resulting in either an acute peritonitis or loculated adhesions containing pus.

Peritonitis may be feared if the handling has been rough, or the operation be prolonged. Long exposure, kinking or injury of the intestines, caused by lysol towels cold sponges, dry antiseptic gauze, antiseptic, and in the carbolic spray, have all in my own experience produced a fatal peritonitis, and I have also seen a volvulus in an abdomen whose contents were easily replaced. Following are the pathological experiences of John Malcolm:—

"If to injury by any other above causes be added such contributory causes as shock, teeming intestinal contents, loose fluid and blood in the peritoneum, the chances are in favour of the development of organisms which are probably always present, but which as the development is slow, and the absorption is rapid, perish in the flower of their age, unwept, unhonoured and unsung."

From the observations on "drains," the peritoneum must secrete a large amount of fluid after an abdominal section, and it is quite clear from remarks one often hears that the fact of the peritoneal cavity being a spring into which lymph is constantly exuding and being drained away by the diaphragm is one little understood though it is the key-note of the treatment.

Bearing this fact in mind it is easy to see why patients do so extremely well after irrigation with hot sterile saline in spite of the shock it causes, and it certainly causes some, but not sufficient to balance the advantages.

The rationale of the irrigation is to clear out the spring and prevent the main stream being foul, and it also restores the lustre of the peritoneum and revives dying epithelium. I saw an acute obstruction washed out and the gangrenous gut looked so healthy that most were in favour of closing up the abdomen, and though the gut

eventually did give way it gave so slowly that adhesions limited the process and a small fistule alone resulted. I have never seen a patient suffer from lavage, and I have seen incalculable good results. It should be warm, 110°, copious, and flushed freely into all parts, and not stopped till the fluid in Douglas' pouch is clear, and not till then should the flushing be discontinued.

The gauze drain, the Keith's tube, the rubber tube, act in a similar manner. They deflect the flow of a suspected infected fluid from the diaphragmatic capillaries and save the system the absorption and destructive septic or toxic material.

In all cases of doubt, drain for twenty-four to forty-eight hours. I have never seen peritonitis follow or arise in a drained peritoneum, and it does not give rise to hernia. Hernia I have seen occur in the other portion of the scar. Vaginal drainage in women is good and safe, but the subsequent dressing is more distressing, and in these days of time saving and diplomacy the reports are all important.

Pus should be drained that way theoretically, but the results have not up to the present been so secure as the other method, partly owing to the difficulty of replacing the drain satisfactorily in the dark up a long tunnel.

The drain should always be in Douglas' pouch, except in septic peritonitis, when drains to each kidney depression and one to Douglas' pouch are imperative.

As regards drains. Keith's tube is rarely used by the most modern surgeons, the risk of injury to the bowel deterring them. Gauze wicks or plugs answer well, but may require an anæsthetic for their removal in private patients, or at any rate cause great pain and take longer, but their value is splendid and undeniable, especially when dense early adhesions are required.

In ordinary drainage for bleeding from adhesions, there is a better method. A large stiff rubber drainage tube of the bore of an index finger *without* holes in the sides, passed well down to Douglas' pouch, and stitched to the abdominal wall, is the best inside, while down to the bottom runs a large iodoform wick, leaving the external tail long. It will draw like magic, the fluid easily collects in Douglas' pouch, *experto crede*, and the gauze sucks it quite steadily dry and can be changed without trouble. When no longer required it comes away easily and a small wick left in twelve hours completes the process.

It is a method that answers in any deep abscess, and it is better than either gauze alone or tube with holes into which the surrounding tissues press and render removal troublesome. For the drainage of gall bladder and gall bladder stump, gauze answers perfectly, but I believe the above method would be equally satisfactory and more comfortable. Mayo-Robson recommends a *similar* method in drainage of gall bladders.

The General Appearance.—The restlessness, the increasing rapidity of the pulse, with a rising temperature; the dryness of the tongue, not moistening and clearing as usual; the persistence of vomiting after the green so-called "anæsthetic" sickness has passed off, and the occurrence of retching and small clear vomits becoming more rapid are the earliest points that may help in the diagnosis of peritonitis. As time goes on the nutrients are retained, but distension becomes apparent slowly, and generally vomiting, instead of lessening, becomes more frequent, the tongue is dry, the pulse rapid, and *the patient's aspect* (most important of all) is one of distress and discomfort. At this stage a smart saline purge and calomel, with a turpentine enema, may, I believe, save cases of incipient peritonitis; it certainly will benefit most conditions.

The onset of peritonitis after abdominal section is somewhat insidious, and requires care, attention and observation. Treves describes the symptoms thus: "Early intense pain, prostration and shock, with retraction of the abdomen and hyperæsthesia; nausea and vomiting, costal respiration, bowels confined, absolute constipation and early meteorism; lies on the back with the knees drawn up, restless and thirsty; a low temperature, with a rapid wiry pulse; a foul, coated tongue, which later becomes brown and dry." A good clinical type, but the stage is too late.

In peritonitis after operation the pain is rarely acute, partly due to effects of the anæsthetic, partly to the general nerve dulling due to the general peritonism and diffuse nature of the poison and to the shock.

Despite many high authorities, I believe that Lawson Tait's views are still to be held in certain cases. It has been shown that at this stage, by John Malcolm and others, that the condition that the saline and turpentine cured was *not* peritonitis, but flatulence and atonic dilatation of the intestine, but I am quite clear that peritonitis often occurs and is cured, and that a certain number of them are stopped from going any further by such treatment.

I saw recently two cases under Dr. Galabin, both of which were enormously distended, and both were apparently extremely ill with the above symptoms, in both purgative and evacuating treatment answered. The first case I believe to have been pure distension and only requiring ʒi. of turpentine and a few grains of calomel in one grain doses, and the last to have been a mixed condition, chiefly due to distension, on the ground that both were so cheerful in their general health, and that the vomiting was not marked nor increasing rapidly.

Intestinal obstruction.—There is nothing more insidious than the appearance of the symptoms of intestinal obstruction, due to an obstruction brought into existence either at the operation or shortly afterwards. The only case I remember well was one in which a doctor, more noted for his zeal than for wise discernment, treated for four days a laparotomy with iced champagne, tincture of iodine, oxalate of cerium, prussic acid, and many other remedies more imposing and popular than scientific or efficacious. He ascribed the whole trouble to post anæsthetic vomiting, and another case of his on which a small loculated operable abscess caused death in four days, together with the above, confirmed an opinion I inherited from a most sagacious and sound observer,

"*that vomiting lasting to the second morning is pathological*," a belief I very strongly hold.

The diagnosis of this condition is so intertwined with the treatment that they should be mentioned together.

In persistent vomiting, which is not green or brown, but causeless and increasing try lavage of the stomach; if it has not been tried, use sodæ bicarbonate and soda-water. If it is due to gastric catarrh the return will be speedy. If due to obstruction the vomit is quiet and not in response to the swallowing and the patients will show by their manner that they feel inclined to vomit unavoidably.

If there is distension increasing and no passage of flatus or fæces, dress the abdominal incision, observe the movement and the distension, and try one ounce of castor oil, one ounce of turpentine, and a pint of hot soap and water, through a long tube passed high up ten to twelve inches or more, the oil first

In peritonitis and atonic dilatation these are often retained.

In obstruction they are returned much as given.

In reflex distension the condition is removed.

Following the experience of Sir Frederick Treves, an additional point is the posture and the behaviour. The peritonitis patient may alone be restless and otherwise free from pain, but the obstruction patient has pain intensifying with the laboured colic of the colon and small intestine which is but seldom absent while the later stages of peritonitis and in the low forms pain is not necessary. I have now seen four cases of acute generalised suppurative peritonitis in which the abdomen moved freely and well and there was no tenderness or pain on ordinary examination, but the patient was toxic. The obstruction patient lies doubled up or tends to. Pressure relieves pain, and he is only restless because of the pain, and he is rigid as a rule. The peritonitis patient is restless, lies without compressing the abdomen, with the knees drawn up but not huddled up, has rigidity early or late of the abdomen, and is more disturbed in face than in obstruction. Meteorism is early in obstruction, but Mr. Symonds says that the early appearance of distension and its continuous pressure points rather to peritonitis. In strangulated hernia distension is by no means an early sign.

If no result occurs, give either colomel or wash out the stomach with weak white mixture, and if any peristalsis occurs, the diagnosis is settled, but if vomiting persists, the prognosis is grave. Operation for intestinal obstruction at this stage is remarkably and painfully unsuccessful in spite of speed, in spite of rapidity, in spite all care. The result is that symptoms of peritonitis occur with great rapidity, and death often follows; *but* it is the only chance, and the sooner the diagnosis is made the better the prognosis, always bearing in mind the value of strychnine and of fluids, and serum subcutaneously before and after. It will usually be obstruction of the small intestine high up, therefore the distension will not be great, as the bowels were probably cleared before the operation. The pulse will be high, and face distressed and pinched, and the vomiting will become fæcal. In my experience actual fæcal brown vomiting *invariably* means obstruction and peritonitis only in the late unoperable stage.

Peritonism. — Injury to the peritoneum producing shock, pain, rigidity, distension, may be avoided by saline injection, by saline pads for the intestines. Paralytic distension or reflex dilatation may occur after extraperitoneal operation and after long peritoneal operations. It is a condition that calls for strychnine by mouth, a flatus tube and turpentine by rectum. It may be distinguished from the distension of peritonitis by its asymnetric character. The abdomen of peritonitis is one blown up uniformly under counter pressure, the abdomen of paralytic distension is not tender but tight, may be indented, and not painful, and the distension is enormous and rapid without marked vomiting or collapse, while the distension of obstruction is not great unless the colon is involved and then is tremendous, and there are also distinct coils as a rule to be made out. Colic distension is more round the circumference and small intestinal distension is more in the hypogastrium, less obvious and more likely to be associated with the obvious painful peristalsis. Peristalsis apart from pain and discomfort is no more significant of obstruction than are the uterine contractions of pregnancy significant of onset of labour.

The above points cannot always be made out, but there is no doubt that in many cases the diagnosis can be justly and successfully made.

The treatment of general peritonitis must be to get the intestines to act, to relieve the distension. If calomel gr. i. every hour or three-quarters of an hour and much turpentine and use of long tube, or the hospital white mixture, will do this, the probability is that the case was not peritonitis, but if these fail to cure peritonitis and (pace—Mr. Symonds, I believe) they do, at any rate, prevent its spread; then a rapid anæsthesia and thorough irrigation and drainage offers the best but still a precarious chance. As regards anæsthetics, people who are acutely ill take A.C.E. very well, and and also take gas and A.C.E. Warmth, speed and avoidance of shock are the keynotes, and patient will come round and not vomit quickly.

In obstruction the use of belladonna and opium is invaluable, but not as a means either of postponing treatment or of facilitating dissolution.

Mr. Symonds intends to try the use of manipulation if obstruction occurs, as the operation itself is so fatal, and the obstruction so often so simple.

Mr. Symonds kindly furnished me with some most accurate clinical observations, which fill one with regret that our most talented observers are too busy to fill the place so much occupied by the busy and garrulous unemployed compiler of books.

Speaking of the value of distension as a symptom after operation he says, "Acute distension has a most grave significance. If it yield in twelve hours to a turpentine enema or a flatus tube, we know it is reflex and not

serious, but if it do not yield or recur, we must look upon it with great concern, for it does not disappear so long as there is progressive peritoneal irritation."

Rarer causes of trouble at the later stages are perforation of a latent ulcer or hæmorrhage, and the irritation of a Spencer Wells, or a sponge, or three even, packed in secure warmth and comfort inside the peritoneum.

Ruptured aneurysm is a raritiy, also hæmorrhage which may occur especially after gastric operations, *e.g.*, gastro-duodenosotomy, and the highest opinions may vary, but the sudden increase in the rapidity of the pulse is the most reliable feature clinically, and the specific gravity test scientifically.

Instruments and sponges I always believed to be rare pathological curiosities, but I have now seen five, and have impending an operation for removal of one to-morrow morning.

They cause unaccountable fæcal fistulæ and chronic pointing abscess, and are not fatal as a rule directly, though they have caused intestinal obstruction. My experience is they are often in Douglas' pouch, where they are at times felt.

Proper attention to toilet and counting is the rule, but the use of *rolls* is the best routine for avoiding the possibility of such a scandalous and indefensible fiasco. I have seen five cases, only one died, and that was independently of the forceps. Do not interfere, they usually come to the surface and then can be removed.

There are one or two isolated points I should like to conclude with.

The first point is *morphia* and the treatment of post-operative insomnia.

Morphia acts like a charm and harmlessly the night after the operation, one-quarter or one-sixth will usually secure a good night, ease and comfort, etc. If vomiting is going on at the time of the last visit I usually employ the "soda-water trick" to finish the vomiting, then morphia immediately after.

Morphia with atropine, I see no advantage beyond theory, and here I believe modern opinion is with me. After the second night insomnia means flatulence, or dyspepsia, or a drug habit, and the appropriate treatment is not symptomatic but carminative. I do not believe in water hypodermics unless a lot of morphia has been given; if it fails the patient's confidence is lost, and the result is poor, but if there is a regular habit of taking any drug like antikamnia in a cachet, sodæ bicarb. will act just as surely.

Chloral and Sulphonal in these cases I feel are unscientific and undesirable, carminatives answer better. People who ask for sulphonal are usually good sleepers or drug takers. There is a great advantage in always giving sleeping draughts, flavoured with some strong disguising drug such as peppermint, and all powders in cachets, it is then impossible for the patient to check the administration, and placebos will act like drugs. For nearly three weeks a cachet full of sodæ bicarb. put an irregular insomnia patient to sleep for six hours, with great gratitude on the recipient's part. Aspirin is a passing fad.

Paraldehyde acts well, and will create no drug habit, and patients do *not* object as much as might be expected. I use it as a safe hypnotic, and as a test of the need for hypnotic.

Hypnal is the only pure hypnotic given in Bright at all frequently.

Pot. brom. and paraldehyde are useful for neurotics *per rectum*, but useless for pain.

The second point is the abuse and use of stimulants. I always feel that the most foolish men use the strongest drugs, and nothing is more ridiculous or unscientific than the use to which stimulants are put.

Some people imagine that the human frame is working on a low gear, the stimulant raises the gear higher and greater speed results. I do not believe stimulants act thus. A stimulant calls on a store of energy to act then, to its detriment at some later time, it hastens the time at which exhaustion will occur.

It has been wisely compared to a lame rat, who was stimulated to jump by cutting off a small piece of its tail till the tail eventually was all gone. So some men pile in stimulants and have no reserve in time of need.

Brandy is useful in limited diseases, like acute sepsis, pneumonia, typhoid, and in collapse and shock, but only as a temporary measure.

Strychnine is a splendid stimulant and should be given in big doses if given for urgent need. I have the greatest faith in strychnine if there is any doubt. If there is no present need and things are on the mend leave well alone, stimulants are not required but given for digestion, as a personal tonic are very good things at meals, champagne and wine particularly.

As regards stimulants before and during an operation, may I quote a hard game of football on a large dry ground is one of the severest tests an individual is put to, and the universal experience of all who have tried stimulants before a game and during a game is that they exhilarate and induce a feeling of omnipotence that does not last, and that men get more out of themselves without them than with them.

Musk is good, but, like oxygen, is a sign of impending dissolution usually indicating that ordinary powerful remedies have failed, and as Treves says, "There is no point in harrassing a dying man because it is the custom."

With regard to this point, it is a question whether thrombosis and flatulence are not avoided by giving alcohol. I am a little inclined to believe this is so, but have no facts to fall back on.

With regard to gynæcological operations, vaginal plugs are taken out the second or third day, and forceps are removed after thirty hours. It is apparently impossible with ordinary care to infect a drained peritoneum or a vaginal operation.

In gastric operation, some feed at once. It can be done, but it is inexpedient. If the button is to hold, it holds at once. The special risk is intestinal obstruction.

In piles and such operations as require quiet in the pelvic region, never give milk; patients will do perfectly for five days on water, beef-tea, Bovril and Valentrine, and the distressing flatulence will be absent.

Sir, I have done. If there is anyone of those who have so patiently borne my discourse who feels edified I shall be proud; if there is any who is bored I am sorry, but if among the many there's any that would discuss it and add to my slender stock of observations by confirming or denying the statements I can promise to be just as attentive a listener, and perhaps a humbler and a wiser man.

I thank you, gentlemen, for the attention and reception you have given me.

Mr. N. Blake-Odgers said it was a most practical paper, but he thought the limitation of ordinary vomiting up to thirty hours was too short, he believed that vomiting as the result of anæsthesia alone was often longer. Paralytic distension he had seen a fatal case of after a fracture. He quoted a case in which the fæcal vomiting was so marked, that peritonitis was thought to be excluded in favour of obstruction, but was actually a ruptured bladder.

Mr. E. Cohen wished all papers were as practical. How did the author explain vomiting for iridectomy lasting thirty-six hours. He believed morphia to be underrated in abdominal operation. How soon would you feed an enterostomy, and a "buttoned stomach"?

Mr. S. Hodgson asked about infusion, and said force was preferable to the hydrostatic method.

Mr. T. H. B. Dodson said atropine was useful in hiccough. He agreed with the necessity and value of gastric lavage. He approved most emphatically of the rule to let digestion wait on appetite. Food they could digest was better than rigid rule.

Mr. J. A. Glover said he was a dying swan as a resident, but he could not resist congratulating his co-dresser. He agreed that for real pain morphia was the only drug, and said pot. brom. even in large doses was useless.

In reply, Mr. Brydone, aided by Mr. Hodgson, said that pure anæsthetic vomiting in skilful hands after good preparation rarely lasted twenty-four hours, and the careful preparation was wanting in Mr. Cohen's case (an emergency iridectomy for glaucoma) and the fracture case. He did not believe attempting to continue the breaking of an alcoholic habit with a surgical operation and so gave alcohol only to the alcoholics, and found the others did better without as a rule; and he thanked the society for the extremely polite attention and for their flattering reception.

Papers by Guy's Men.

Advances in the Treatment of Paralytic Deformities. By A. H. Tubby, M.S. Lond., F.R.C.S. Eng.—*The Lancet*, 28th March.

Further Observations upon the Respiratory Exchange and Temperature of Hibernating Animals. By Dr. M. S. Pembrey.—*Journal of Physiology*, March, 1903.

In Lighter Vein.

The Annual Gentlemen's Night of the Nurses' Debating Society was held on the 1st of April, in the Swimming Bath. University costume was worn. The chair was taken punctually at eight o'clock by the president, the Chaplain, resplendent in a halo of pink roses, who called on the secretary to read the minutes of the previous meeting. The business of the House was then commenced by the chairman calling on Nurse Mary to move that—

"It is love that makes the world go round."

Her speech has been unfortunately lost. Nurse Outers then rose to oppose. She also lost her speech. The chairman then declared the subject open to debate.

Mr. Wrench thereupon rose with the air of a conqueror and smiled upon the audience. He believed, he said, that the earth was round, and proceeded to discuss with considerable skill the progress of art and morality in prehistoric days. Smiling once more, he said that he had frequently been in love, and proceeded to give an accurate and detailed description of his last flame. Several members of the society were observed to blush. It was his fatal beauty that did it. He could not help it. Once more he smiled. What a thing it was to be beautiful! He then smiled four times in rapid succession and sat down.

Mr. Brydone rose to oppose. His face, he said, was not what the vulgar herd would call beautiful. It was of a rarer type only appreciated by connoisseurs and specialists in pathology. He was a beautiful specimen. Everyone would admit that Guy's Hospital made the world revolve, and they would also admit that it was he who ran Guy's Hospital. Even his smiling friend opposite could draw the logical conclusion from those premises. How did he do it? By love alone! He then burst into song. The audience burst into tears.

Mr. Bolus then rose to explain why he wore a red waistcoat. During a lengthy speech he referred to most of the standard works of Physiology, and gave several of the junior staff a leg up.

Mr. FORSYTH next spoke, and explained that this was his first appearance since he had got on the staff. He had had considerable difficulty in obtaining a hat commensurate with the dignity of his office. Continuing, he remarked that he had not the slightest knowledge why the world went round, but was prepared to admit the efficacy of love. Personally, he had never been in love, but had met several who had. For instance—here the chairman called him sternly to order, and the House breathed more freely.

A large number of nurses then got up and all spoke together. After the restoration of order Mr. PALLANT rose, and remarked that he had a very neat ankle. (Tumultuous applause.) When he grew up he should go in for the new fashionable short skirts, that he would. He didn't know much about the world, but he liked girls, he did.

Mr. RAY-EDRIDGE stated, on oath, that he was the secretary of the rival male show. He wasn't much of a hand at speaking, but he was uncommonly good at recitations. With the permission of the audience he would give a selection from his repertoire. The audience stood it for ten minutes, then Mr. HODGSON arose and demanded attention. Unfortunately, he insisted on repeating such portions of his speech on Napoleon as he could remember, and met with a chilling reception. Before his final suppression he had coughed up a lot about Fashoda and the glorious British Empire.

The Chairman next rose, and asked leave to address a few words to his dear friends on this solemn occasion. He himself had known the fatal flame. He had caught it in several places at once. But far from objecting to the experience, he rejoiced in it. Oh yes, dear friends, was it not a glorious thing, was it not a noble thing, to realise that one was aiding in the good work of shoving round the world? He had a mission and he would nobly perform that mission, even at great personal inconvenience to himself, in season and out of season, in the wards and out of the wards, by day or night. The world must go round, and his fellow-workers had said, and it seemed to him with great truth, that love made it gyrate. Therefore, he would strive, with all his heart and with all his soul. He was not afraid of anyone except the mat—— At this juncture Mr. Barnes turned on the water, and the meeting ended in disorder.

ALI BABA.

From the Gazette's Special Pathologist.

H., RAMSGATE.—The sputum was muco-purulent in character, but no tubercle bacilli could be detected in it.

G. M. J., ALTON.—This specimen contained a considerable number of tubercle bacilli (marked No. 1).

G. M. J., ALTON (marked No. 2).—This specimen contained a fair number of tubercle bacilli.

PATHOLOGIST.

Appointments.

CIVIL.

C. J. SYMONDS, Esq., M.S., F.R.C.S., has been appointed Examiner in Surgery by the University of London.

MR. WILLIAM A. MAGGS has been elected a member of the Examining Board in Dental Surgery by the Council of the Royal College of Surgeons of England.

NAVAL AND MILITARY.

Staff-Surgeons J. DOUGLAS HUGHES and NORMAN L. RICHARDS have been appointed to the *Pioneer* and *Nelson* respectively.

Surgeon R. W. B. HALL, R.N., has been appointed to the *Edgar*.

Colonel F. W. TREVOR, R.A.M.C., has been appointed Principal Medical Officer, Scottish District, *vice* Colonel J. P. Rooney, retiring on account of age.

Lieutenant M. H. THORNELY, I.M.S., is promoted to be Captain.

Births.

DUFFETT.—On March 31st, at Withy Holt, Sidcup, the wife of Henry Allcrott Duffett, F.R.C.S., of a son.

GODSON.—On March 30th, at Linden House, Cheadle, the wife of John H. Godson, M.B., of a daughter.

SMITH.—On March 29th, at 204, Selhurst Road, South Norwood, the wife of Walter H. M. Smith, L.R.C.P. Lond., M.R.C.S., of a son.

WALLIS.—On March 10th, at Beverley, near Hull, the wife of Herbert Wallis, L.D.S. Eng., of a daughter.

Death.

BARLOW.—On March 27th, at Orlebar, St. Peter's, Kent, Robert Barlow, M.R.C.S. Eng., aged 64 years.

ED.—J. M. B.

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Calendar of Coming Events.

April, 1903.

Sat. 25.—Messrs. Symonds and Stewart's take-in; Drs., G. E. F. Robinson and G. H. Rees; Cl., G. E. Malcomson.

Tues. 28.—Cambridge Third M.B. Exam. begins.

May, 1903.

Fri. 1.—Summer Session begins.
Probable date of 1st Professional and Final L.D.S. Eng. Exams.

Sat. 2.—G.H.L.T.C., I., Trial match, home.

Mon. 4.—Final M.B. Lond. Exam. begins.
G.H.C.C., III., v. New Eltham, 2 p.m., home.
Practical Exams. for Dental Prizes begin.
Extractions 9 a.m.

Wed. 6.—1.30 p.m., Clinical lecture by Dr. Fawcett.
G.H.C.C., II., v. Merchant Taylors School "A," 2 p.m., home.
Dr. Eyre lectures on Bacteriology at 9.30 a.m.

Fri. 8.—1.15 p.m., Clinical lecture by Mr. Lane.

Sat. 9.—G.H.C.C., I., v. Beckenham, 11 a.m., home.
II., v. Old Charlton, 2 p.m., home.
G.H.L.T.C., I., v. Sidcup, home.

Guy's Hospital Gazette,

APRIL 25, 1903.

The Antimony Poisoning Case.

It is well to place on record the case of Maude Marsh, as it affects Guy's Hospital, both for the purpose of vindicating, if necessary, the part we played in the grim Borough tragedy, and to expose the ignorant or ill-informed remarks of the learned judge.

Maude Marsh, æt. 19, stated to be married, came to the Surgery, July 28th, with a friend, in a state of collapse with acute pelvic pain, vomiting, and a raised temperature.

The diagnosis of the Receiving Officer was that there was probably pelvic peritonitis, and she was admitted, without question, as an urgent case, acutely and dangerously ill. She was a difficult patient, and examination was always resisted and unsatisfactory, and it must be remembered patients are free agents. Her temperature was 103°, pulse very rapid and weak.

Her condition rapidly improved, and as her recovery was only a matter of time, nothing was done, and she left practically well. Klosowski came to visit her almost immediately after admission, and wished to take her home. She *asked* the Resident House-Surgeon not to let her go, but he had refused his assent to her removal in her then critical condition.

Klosowski was detected and forestalled in an attempt to give her food during his visit (a very common, every-day visitors' offence), but his hold over the unfortunate girl was so great that she was willing to accompany him home, but for the very decided remark made to him by the Resident.

"If you take her home and she dies I will inform the Coroner and get an inquest," a fact that sufficiently indicates the suspicion that rested on his behaviour. Klosowski's insolent demeanour changed at once, and his behaviour was absolutely cringing.

She rapidly improved, and after three weeks went out fairly recovered. The report is headed, ? "Tuberculous salpingitis," and the verdict recorded is "Relieved."

The case there ends as regards the hospital.

The absurd objection that Justice Grantham raised to the wife of a licensed victualler being admitted is met at once by the fact that she was acutely and dangerously ill and could not be sent away, had she been Lady Grantham she would equally have been admitted, and with equal right—that of urgency.

The other point, that Guy's failed to recognise antimony poisoning, is the medical one that the diagnosis of all acute abdominal disease from ptomaine poisoning is often difficult, and that the effects produced by irritant poisons of any

nature are so similar in their action that the cause is always most difficult to be sure of, and as the patient was rapidly recovering there was no suspicion raised that it was anything more than a pelvic peritonitis, which it very much resembled, or an acute illness, possibly a gastro-enteritis--a very common summer disease.

Dr. Stoker, to whose persistence the post-mortem and investigation was originally due, deserves, in our opinion, the highest credit for his action, and it is absurd to say that the discovery was not due to him. To his suspicions the post-mortem was due, and from Dr. Grapel's reflections the suggestion of arsenic first came, while Dr. Stevenson's expert knowledge and skilled investigation clinched the diagnosis.

If death certification and Coroners' inquests were reformed, and an official of the standing of a Coroner's clerk replaced the ordinary officer as the official to be consulted, the friction and annoyance that often occurs would be saved, but also the risk of undetected murderers escaping would be greatly diminished, but at present the chaotic practice of registration, and inquests without post-mortems, are but playing into the hands of expert criminals like Klosowski.

Before denouncing a husband as the murderer of his wife something more tangible than inability to make a diagnosis of the cause must be present, and there is in these days of antagonism between the medical profession and *some* Coroners no intermediate course.

Private Nursing from Guy's.

At the recent meeting of the Royal National Pension Fund for Nurses hearty commendation was bestowed by the chairman (Sir Henry Burdett) on the scheme that is in operation at the "Institution," and it would be perhaps well to restate the position and to call attention to the scheme and its manifold advantages.

The Private Nurses are those who have joined the Hospital Staff permanently after qualifying by three years' training, and after gaining a first-class certificate. Each nurse receives £25 the first year, rising by £5 a year to £40.

Nurses are compelled to take out a policy for an Annual Pension of not less than £7 10s. at the age of fifty (about a guinea a year ordinarily). Premium varying according to age.

The Institution on behalf of the nurse takes out also a policy for an addition of £11 5s., the policy is assigned to the nurse should she leave the Institution after not less than two years' service.

After being at the Institution four and a quarter years each nurse is entitled to draw on the Bonus Fund which is added to her Pension Fund. At any time after two years the contributions with 3 per cent. compound interest may be returned on withdrawal. Thus far there is little that is remarkable or unusual.

It was pointed out at the meeting that a charitable institution ought not to farm out nurses, and make a profit out of the work of the nurses, and the scheme was thus outlined by Sir Henry Burdett.

"Out of the profit made by the work of the Institution—the private nursing staff—a sum shall be taken at the discretion of the Treasurer and divided among the nurses.

"A nurse who has completed five or six or seven years or up to nine years' service is entitled to four or five or six or up to eight shares.

"The Bonus Fund consists of the net profits made by the Staff of the Institution.

"The Institution intimates to the Pension Fund what the actual value of a share is in a particular year, how many shares each nurse is entitled to, and then the Institute purchases a policy in the Pension Fund for what sum is produced by each nurse's share, the annuity commencing in the case of these nurses at fifty-five years of age. The scheme has now been working for seven or eight years, and the Superintendent, Dr. Perry, says it is quite clear that the majority of nurses of the private Staff will be able to retire with a pension of at least £50 per annum."

The nurses are entitled to indoor and outdoor uniform and board and lodging in the institution with free laundry, and to four weeks' holiday in the year.

If she should not live to claim her annuity all her payments are returned and may be applied as she directs by will or else belong to her next of kin.

Two Cases of Paralysis in Children.

CLINICAL LECTURE BY Dr. F. TAYLOR.
March 7th, 1903.

Gentlemen,—The two cases upon which I wish to speak to-day have been under my care in Philip ward, but are now temporarily under the care of Dr. Shaw.

I will first remind you of some facts in the anatomy and physiology of the nervous system. Paralysis, in the sense in which we ordinarily use the term, means loss of voluntary power to contract muscles; and it is dependent upon inability to originate motor impulses in the nerve centres or to transmit them along the nerve channels from the brain to the muscles. The paths of impulses, as you very well know, are from the cortex of the brain, through the internal capsule, along the pyramidal tract, across the medulla oblongata in the decussation of the pyramids, and into the anterior cornua. Thence the impulses pass through the nerve fibres to the muscle. Now, the interruption of this channel at any part leads to paralysis. Further, we know anatomically that this path can be broken up into two portions, one of which consists of a nerve ganglion, or cell-body, in the cortex of the brain, with its corresponding nerve fibre, which can be traced down to some point in the anterior gray matter of the spinal cord. The other portion consists of a ganglion-cell in the anterior gray matter or anterior gray cornu with its nerve fibre passing through the anterior root and motor nerve to the muscle.

During the last few years we have learnt to call those structures "neurons:" each neuron consisting of the nerve-cell with its associated nerve fibre and axis-cylinder; each neuron complete in itself and not in actual structural connection with anything else. For the axon terminates in a plexus or arborization which surrounds the cell-body of another neuron, but is not in structural continuity with it. It is convenient to call the neuron which I first described an upper neuron, and the other a lower neuron. Of course these terms upper and lower must be understood in a physiological sense as the eqivalents of central and peripheral. For the lower ends of some "upper neurons" are near the filum terminale of the spinal cord, whereas some "lower neurons" are distributed in the occipito-frontalis muscle.

The object of our investigations in a case of paralysis is, first of all, to find out where the lesion is. If you have a patient who is paralysed in one or other part of the body, you want to know in what part of this long tract from the brain to the muscle the lesion has occurred, whether it is near the muscle or in the nerve-trunk, in the lower or the upper part of the spinal cord, in the bulb or the pons, in the pyramidal tract or in the cerebral cortex. Now, this concurrence of two separate neurons, or cell and nerve arrangements, in the transmission of impulses from the brain to the muscle, has a certain value for us, since it may very much assist us in locating the lesion. Supposing, for instance, you had one long fibre going to the muscle from the brain, you would have much more difficulty in determining where the lesion was, because the symptoms would be very much the same wherever the lesion was. But we can get a great deal of help by studying the characteristics of the case in connection with our knowledge of the functions which the two neurons subserve. The cell-bodies of these *upper* neurons are those which originate motor impulses—I use the term without any reference to the question of how far all our processes, even voluntary acts, are reflex—and such impulses are transmitted down to the point of connection of these neurons with the cell-bodies of the *lower* neurons in the anterior cornu of the spinal cord. The functions of the upper neuron in relation to the muscle are the origination and transmission of this motor impulse. But the lower neuron not only takes up the impulses which it receives from the upper neuron, and so contributes to voluntary muscular contraction, but it is also excited by impulses brought to it by afferent spinal nerves, and it has a very important influence upon the structure and nutrition of the muscle. As a result of this first connection, the lower neuron shares in the so-called reflex process, or spinal reflex. Secondly, the nutrition of the muscle depends absolutely upon the integrity of the neurons

immediately connected with it, that is the lower neurons; and if the nerve is cut across or permanently damaged, or if the nerve-cell is inflamed or atrophied in the interior of the spinal cord, the muscle wastes. Thirdly, with the nutrition of the muscle goes another important physiological phenomenon, the electrical reaction of the muscle, and this will be modified or lost if the nutrition is materially affected.

Thus we have four well-defined functions of the lower neuron: the direct transmission of motor impulses; the reflex origination or transmission of motor impulses; the nutrition of the muscle; the electrical reaction of the muscle. On the other hand, the upper neuron is in less close relation to the muscle. However much you damage the upper neuron, the muscle will continue to be well nourished. The reflexes are not abolished by damage to the upper neuron, nor are the electrical reactions affected.

Now, upon that broad and important distinction in the functions and operations of these neurons is based the chief method we have of differentiating between one kind of paralysis and another, and thus making a definite start in the diagnosis of our case. With regard to the reflex actions, there is another important point to be noted, and it is this: if the upper neuron is damaged, so as to hinder the passage of impulses from the brain to the anterior cornu of the spinal cord, then the natural cerebral control or inhibition of the reflex process is lost, and the reflex process is not only not abolished but it is more active and lively than it normally should be. There is, first, an exaggeration of the reflexes, both superficial and deep, illustrated in the lower extremities by increased knee-jerk, by ankle clonus, and by the now familiar Babinski's sign of extension of the toes on stimulation of the sole of the foot. Secondly, there is a condition for which you should be careful to look, namely, spasticity or rigidity or stiffness of the muscles, obvious enough on mere handling of the limb in severe cases, but requiring careful manipulation to demonstrate it in less marked instances.

Different views have been held as to the cause of this condition; but that generally held at the present time is that it is a persistent reflex following from the persistent stimulation of the surface from which no one can escape. Whether you are sitting in an arm-chair or walking about, there is a constant flow of afferent stimuli from the surface of the body, which, under these conditions of abolition of control, are likely to set up a persistent reflex of more or less intensity in the neurons which are below and unaffected.

I will now try to illustrate these remarks and point out their bearing in diagnosing the two cases I have to speak about.

The first case is that of a girl æt. 14 years, who was admitted into the hospital on the 24th January. The history is to this effect: She was perfectly well until the first week of November, when on her return from school one day she complained of a bad headache. She was put to bed, and on the next day the headache was much worse. A doctor was called in, and a suspicion of muscular rheumatism was entertained, as a provisional diagnosis. The girl was, however, light-headed, feverish, and complained of pains in her limbs. Three or four days afterwards her mother was taking her to the bath when her legs gave way under her, and she was unable to walk. The arms and legs soon became useless. After about a month she regained complete use of her arms, but the legs remained paralysed. I saw her on January 21st, a few days before she came into the hospital, that is, after she had been ill six weeks. There is now no very material alteration to report in her condition, except some little increase in the amount of power she can exert. She is in good general health, of a good colour, lively, and intelligent. She has almost complete paralysis of the left lower extremity; as she is recumbent in bed the foot lies extended, dropped by its own weight. If she is asked to move that leg she simply contracts some muscles in the flank or loins in such a way as to shift the leg slightly up and down in the bed; there is no observable contraction of the muscles of the thigh, or leg, or foot. The right lower extremity is in a very similar condition to the left, but with this difference, that with a good deal of effort she can rotate the limb a little at the hip, can

slightly flex the foot at the ankle, and can flex the toes a very little.

Another interesting condition is paralysis of the abdominal muscles. On being asked to cough it is observed that she cannot do it effectively; she drives a little air through the larynx, but her abdominal muscles will not contract sufficiently to produce an adequate expiratory coughing effort. If a healthy person is asked to raise the head from the pillow the recti abdominis muscles invariably contract. If our patient is asked to do this, she raises the head, it is true; but it is by the action of cervical muscles alone, and the recti muscles do not help her by any visible or palpable contraction. In her back and loins also there is a very obvious defect in muscular power as well as nutrition. The latter is well shown by the extreme flaccidity of the muscles; for there is an obvious want of substance in the lumbar spinal region, so that you can feel the lumbar transverse processes with great facility in a girl who, though not fat, is very well nourished. All of these paralysed muscles are flaccid, flabby, soft, wanting in tone. This condition in the left lower extremity extends to the gluteal region, which is obviously softer and more flabby than the right. The reflexes are absent; there is no knee-jerk, no plantar reflex, and no clonus. Those of the muscles which have been tested show no electrical reaction, namely, the right rectus femoris, the sartorius, the quadriceps, the vasti, the tibialis anticus, and the left peroneus longus.

Here, therefore, we have the precise condition I have specified as illustrating a lesion in the lower neuron. I will presently point out to you the diagnosis which we arrive at as a consequence.

I will now briefly take up the second case, that of a boy, æt. 10 years. In his case we have a much less perfect history than with the girl. It is said that the father died of consumption; the mother is well and in service, but delicate. The boy has always been weakly and delicate, and ever since birth his right leg has been weak. We have no accurate account of the course of his illness, as we have not been able to see his mother, but the boy seems to have been paralysed for a long time. When he came in he was a deformed weakly looking boy, with a thin face, clear complexion, and reddish hair. His usual position in bed is on his back with the shoulders much drawn up and the head thrown forward; the legs are crossed from the knees downwards, the left leg being above the right. He is unable to sit up in bed unsupported.

The chest is flat and narrow above, but the sternum is pushed forward below, and the left side of the thorax is more prominent than the right. There is a lateral curvature of the spine convex to the left extending from the fifth cervical to the seventh dorsal vertebræ, and the seventh cervical and first dorsal vertebræ project backwards to form an angular prominence. The right arm is normal; the left arm is atrophied below the elbow, and the muscles of the forearm and those of the thenar eminence are much wasted. The fingers of this hand are flexed; he is unable to open them, and they resist attempts to straighten them in passive extension. He can grasp objects with a slight amount of force. The movements of flexion and extension at the wrist are nearly normal, those at the elbow quite so.

The left leg is slightly wasted but the muscles are firm and the limb rather rigid; the foot is inverted. He can move his toes but not the ankle joint. The knee is in a state of semi-flexion; he can flex it completely but is unable to extend it. There is free movement in the hip. Sensation is good; the right leg is thinner than the left. The foot is inverted to an angle of about 90°. The whole foot is rotated inwards and the metatarsus is turned at right angles to the tarsus. The knee-jerk is markedly exaggerated in both legs. In the left leg there is a well marked ankle clonus, and this phenomenon was also obtained slightly in the right.

The patient, then, is the subject of some lateral curvature in the upper part of the thorax, and a very definite angular curvature or kyphosis, involving the lowest cervical and the first dorsal vertebræ. In this case, it is true, we have a certain amount of wasting, but there is not the same flabby and flaccid condition of the muscles as we found in the first case. There is weakness with rigidity, and increase of reflexes. These are the conditions which I have told you

are likely to arise when there is a lesion of the upper neuron. In the upper extremity the muscles of the thenar eminence fail to react to faradism, and show the reaction of degeneration to galvanism. The reaction of the muscles of the lower extremity is not stated, but I think it will be found that they are practically normal. Thus you see these two cases of paralysis do contrast very definitely with one another.

Let us now take the girl's case in more detail. She has freedom from paralysis in her head, arms, and upper part of the body, but has the paralysis of the muscles of the abdomen and thighs and legs which I have pointed out. She has no affection of sensation, no numbness, no pain, and no affection of the bladder or rectum. For the further discrimination of the site of the lesion one has to start from the lower neuron. Anatomically one may divide the lower neuron into three portions, and the lesion may be (1) in the cell-body, which is situated in the anterior horn of the spinal cord, or (2) in the anterior roots outside the cord, or (3) in the nerve trunk and its motor branches. In the first two situations the lower neuron is free or independent as a motor agent. It is when the anterior joins the posterior root that the motor fibre becomes associated with the sensory fibres contained in the latter. If there were a lesion of the nerve trunk we should expect the sensory function to be involved as well as the motor. But in this case there is no numbness nor other affection of sensation. That is a proof that the nerves themselves are not primarily affected by any gross lesion; and there is no extensive inflammation or pressure affecting the whole of the nerve trunk. Therefore the lesion must be in the anterior cornu, or in the anterior nerve roots. Experience has not made us acquainted with a disease involving the anterior roots alone so as to cause such an extensive paralysis as this.

On the other hand, we are familiar with disease implicating extensive areas of the anterior gray matter of the spinal cord; and this disease which is an acute inflammatory process is called acute anterior poliomyelitis, meaning myelitis of the gray matter, or acute cornual myelitis. Every fact of the case points in this direction; it was an acute illness, partaking in many ways of the features of an acute infection; there was severe headache, pain over the limbs in general, and probably not depending on any particular nerves, but the kind of pain which one is apt to get in any infectious disease. In the course of a few days the motor defect was discovered; she recovered from the general illness, but remained damaged in consequence of the lesion in the anterior cornua. You must imagine that in this case a large number of the anterior cornua have been affected in the lower dorsal and lumbar regions. This history is a common one. Numbers of cases in which this disease occurs begin with either a feverish attack, or, in smaller children, with convulsions, or with general intense pain—sometimes intense local pain—which passes off after a time. Then in such cases it is not at all uncommon to find three or four limbs affected first of all, for one or two limbs to get better, and for the others to remain permanently affected. For the most part this disease occurs sporadically, and it is not possible to say in particular cases what is the cause; but cases are on record of its occurrence in two or three members of the same family—or in small local epidemics.

In this it has some likeness to an infectious disease, and viewed in this light its onset becomes more intelligible, though we have no definite information as to any micro-organism which can be the cause of it. The disease is so frequent in children that it has been commonly known as infantile paralysis; and if that name is applied to any case of disease without qualification, anterior poliomyelitis is meant. It occurs, however, in adults, and as it can then scarcely be called infantile paralysis, the name of adult spinal paralysis has been used for it.

But it is obviously inconvenient to have two names for the same disease, and acute anterior poliomyelitis is a correct pathological designation, and would be quite satisfactory if it were not so long.

I should like to refer, in passing, to another point, and that is, that the term infantile paralysis not only has the inconvenience of so naming a disease which is not confined to infantile periods, but the term does not include

all the cases of paralysis which occur in those of tender age; that is, in children more than one form of paralysis may be met with. The second case I have narrated already is an instance. It is not an anterior poliomyelitis but a compression-paraplegia, complicated in a way I shall mention presently. Children, also, are subject from time to time to cerebral hemiplegia, that is a one-sided paralysis starting from a lesion in the brain. The only justification for the restriction of the term to cases like that of our female patient is that whereas compression-paraplegia and allied spinal forms, and cerebral hemiplegia are more common in adults than in children, acute anterior poliomyelitis is much more common in children.

The lesion in our second case is undoubtedly of a tubercular nature, and tubercle is very frequent in children, at any rate in early life; but it is sufficiently frequent after childhood, and other causes of spinal-compression and localised lesion are much more common in adults.

With regard to hemiplegia, the common cause of that in grown-up persons is the occurrence of degenerative changes in the vessels, which changes, of course, are not so likely to occur in children. In children the lesions which occur to cause paralysis of one side of the body and the arm and leg on the opposite side are (1) thrombosis of cerebral vessels, especially in connection with febrile diseases like measles and scarlet fever, and (2) embolism of cerebral arteries where the patient already has rheumatic endocarditis with valvular lesions. But there is one form of cerebral paralysis in children which is very largely limited to infancy, for the opportunity for its occurrence is much less in adults. I mean the paralysis of both legs and one arm, or both legs alone, or all four limbs, which results from compression of the skull during the process of delivery, sometimes in association with the use of forceps, sometimes from prolonged compression during delivery, causing damage to the surface of the brain. The nearest approach to it in later life will be in a case of very chronic syphilitic meningitis, or pachymeningitis arising in association with degenerative processes, of which excessive alcoholic indulgence may be the antecedent. But after all those conditions seldom cause a state like that of cerebral paraplegia.

There is yet another form of infantile or children's paralysis, and that is one due to neuritis, producing again an affection of the lower neurons. You know that very many of the infective processes are liable to give rise to neuritis at some time or other, such as influenza, typhoid fever, septicæmia, but especially diphtheria, and this is the most common cause of a neuritis in children, forming the disease often known as diphtheritic paralysis.

The boy's lesion I have intimated, rather than actually stated, is one of the upper neuron and is brought about in the following manner. Tubercular disease attacks the vertebræ, beginning in the edges of the bodies of the vertebræ, close to the intervertebral substance, and destroying the bone and the cartilage, so that the bodies of the vertebræ fall together, the spinal column is distorted, and kyphosis, or angular curvature, ensues. The chief cause of pressure on the spinal cord and of the resulting paralysis is not the curvature of the spine but the formation of caseous tubercular masses and abscesses in the spinal canal, which project and press upon the contents of the canal.

Such a condition was shown to be present in this case; for, the day before yesterday, Mr. Lane operated upon it, performing laminectomy, and removing the posterior part of the vertebræ. He found some pus and caseous matter in the spinal canal, and material of this kind was scraped away from the bodies of the seventh cervical and first dorsal vertebræ.

Observe that the main part of the pressure comes upon the front of the spinal cord from the posterior part of the bodies of the vertebræ. In the antero-lateral tracts of the spinal cord are the nerve fibres which contain these upper neurons; and it is a very noticeable thing that in a great number of these cases we have only partial results; not complete paralysis, not complete rigidity, and certainly not complete loss of sensation, but moderate loss of power with rigidity and increased reflexes in consequence of impairment of transmission of impulses, both for muscular contraction and for control of reflex. Observe further that, in this case, in

connection with the region where the lesion exists, we have some paralytic conditions which correspond to affections of the lower neuron; namely, wasting of some muscles, with loss of electrical reactions. The thenar eminence, which has been shown to be wasted, has lost its electrical reactions; and that loss would result from a lesion of the lower neuron. You will understand readily that if pressure is exerted on the anterior nerve roots instead of the pyramidal fibres, it is the lower neurons in connection with the muscles of the upper extremity which will be involved and not the upper neurons. You know that the nerves forming the brachial plexus are the last four cervical nerves and the first dorsal nerve. The lesion of the spinal column is situate at the level of the seventh cervical and the first dorsal vertebræ, and it is easy to understand how, with this effused material, the lower nerves of the brachial plexus may be compressed.

This case is interesting because it presents a little point of difference from the great majority of cases of Pott's disease, or spinal caries, namely, that in addition to the lower extremities being paralysed, which is common, the upper extremity is partially paralysed, and that in respect not only of its upper neurons but of its lower neurons also. In the greater number of cases of Pott's disease the lesion is below the first dorsal vertebræ, and then the nerves of the upper extremity escape.

What I have been principally trying to impress upon you is the difference between the effects produced by lesions in the upper and lower neurons; that is the first fact that you have to lay hold of in the consideration of any case of motor paralysis you have to do with.

It is impossible to give you in one lecture all the points and the means by which you can discriminate and further fix the point of origin of the disease in any other part of the body.

I have scarcely touched upon cerebral paralysis; I have discriminated only between a lesion of the anterior cornu and one of the pyramidal tracts in the spinal cord. The diagnosis of higher, lesions in the pons varolii, the medulla oblongata, or the brain generally, would occupy much more time, but the points I have gone over are those to which your attention will have constantly to be directed.

Two Cases for Diagnosis.

I.—F. M., æt. 36, was admitted into "Queen" on March 26th. Patient has been married eighteen years. Her husband, a coast-guard, is alive and well.

Patient gives a history of a sudden onset of pain on March 15th—she complains of continuous aching pain in the abdomen since that date.

History of present complaint. — Patient was feeling poorly on March 13th and 14th. On March 15th, she was lying down on the rug in front of the fire when she was suddenly seized with an attack of pain in the abdomen, "which doubled her up." The pain passed off in an hour or two, and she went to see a doctor, who ordered her medicine, and told her to go to bed. There was some sickness with the attack of pain, but this symptom did not last. Next morning (16th) she found she was menstruating and lost a small quantity of blood all that day. There was no further loss on the 17th. The following day, she was examined by her doctor, and told that she had a tumour in the abdomen. She was advised to come up for operation. Up to this time patient had no idea of the presence of a tumour, nor had she noticed any increase in size of the abdomen.

Pregnancies.—She has had no children or miscarriages.

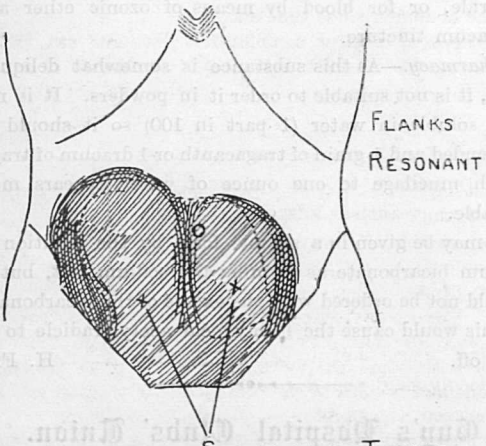
Menstruation.—Began at the age of sixteen; for the first three years she hardly saw anything at all. Since then she has always been irregular, sometimes going six weeks or two months and occasionally only one month. She has always lost very little and latterly has been losing still less. Menstruation usually lasts three days. She is liable to some pain for a day or two before the periods come on. The last menstruation was on March 16th.

Medical history.—Patient married when eighteen years old. She seems to have been a healthy woman all her life. For a few years after marriage, while stationed in Lincolnshire, she was liable to attacks of asthma, but with this exception, she has had no illness. Patient has never had any children, but volunteers the statement that she has no desire in that direction. For the last four or five months she has been ailing, and has suffered from continuous aching pain in the stomach, more especially on the right side. The pain has been worse at some times than others but does not seem to have any definite relation to food. At the same time, she has kept about at her work, right up to the time of the onset of acute symptoms mentioned above. Her occupation is that of a caretaker. The work is at times heavy. The appetite has latterly been poor, and for the past six months she seems to have lived on quite a light diet. Micturition has always been performed without any difficulty. She is liable to constipation. She has never at any time suffered from any vaginal discharge.

Present condition.—Pulse 110, temperature 101°, respiration 32. Patient looks pale and tired, but says she feels fairly well in herself, except for the pain. *Urine.*—A catheter specimen is neutral in reaction, and contains no abnormal constituent.

Respiratory system.—There are signs of bronchitis.

Abdominally.—A large tumour can be felt, situated chiefly below and to the right of the umbilicus. It is not freely movable; distinctly tender on palpation, especially immediately below and to the right of the umbilicus. Its surface is smooth and there is apparently



Situation of Tumour

a depression down the middle. The tumour does not feel very hard; it is dull on percussion. A thrill can be obtained. The flanks are resonant.

Per vaginam.—The posterior fornix is practically obliterated by the bulging into it of a tumour, which can be felt bi-manually. The cervix is normal. No signs of pregnancy. The body of the uterus could not be felt.

(For Solution see p. 184.)

II.—Alice N., æt. 36, a married woman with five children, was admitted April 15th for abdominal pain and vomiting.

Previous history.—Patient had always been a very healthy woman, and could remember no previous serious illness. She had never had any indigestion, and there was no history of any abdominal pain, or vomiting, before the present attack. Patient had been regular since the birth of her last child, four years previously. Patient had taken a moderate amount of alcohol. There is a vague history of a blow in the epigastrium before the onset of the illness.

Present illness.—On Friday, April 10th, patient was doing some washing in a draughty out-house when she was suddenly seized with abdominal pain, and felt very ill. The pain was in the upper part of the abdomen, more especially the right hypochrondrium. She was not sick at once, but vomited some brandy she took for the pain. She went to bed and remained there on Saturday, the pain continuing. On Sunday she was up and about, but feeling weak and ill. On Monday she got up, but fell down stairs, owing, she imagined, to the weakness. On Monday night the pain became very severe, and she awoke suddenly in the night and began to vomit; the pain became very severe when she took a deep breath. Vomiting and pain continued. A doctor was called in, and prescribed morphia and hot poultices. Everything patient took was returned. The vomit was not dark or offensive. On Wednesday, April 15th, about 10 p.m., patient was brought to Guy's and admitted.

Condition on admission—Pulse 134, temperature 100·2°, respiration 25. Patient appears in great pain which seizes her at intervals, especially on taking a deep breath. The pulse is small, but regular and rapid. Expression not particularly anxious. Tongue moist, slightly furred. Abdomen somewhat distended, slightly more prominent to the right of the umbilicus. Patient cannot take a deep breath without pain, when she does so the abdomen moves and she cries out, and complains of a stabbing pain. The abdomen is tender, especially in the right hypochondrium, and the upper part on both sides, but there is some tenderness all over. The abdominal wall is rigid, and nothing abnormal can be felt. Percussion is well borne, the abdomen is resonant all over. The liver dulness is not obliterated. The lungs appear normal, but owing to the shallow breathing little vesicular murmur can be heard. The entry at the right base seems specially deficient, and a "rub" was occasionally heard in this situation by the physician alone. Knee jerks present. Pupils contracted.

Patient remained in about the same condition after admission. Normal saline, a pint every four hours was injected per rectum, and injections of strychnine given. As patient remained restless, and in much pain, and continued bringing up small quantities of bile-stained fluid, morphia (a quarter of a grain) was given subcutaneously. Patient passed a fairly quiet night, but in the morning the condition resembled that on admission. About noon she vomited half a pint of dark fluid. She vomited for first twelve hours only once, and it was a deep green and not offensive. Next morning when it began to increase it was dark brown and became black and was gushing in character. Nothing made out per rectum or per vaginam. Urine normal in appearance except for excess of urates. No tests were made as the specimen was unfortunately upset. The bowels had not been open since a normal motion on Monday, three days previously, and no flatus nor fæces were passed in the hospital. The abdomen was opened at 1 p.m. Before operation, as compared with the condition on admission, she was a little more distressed. There was vomiting, but not to any great extent. The distension was not increased. The tongue moist and not brown. The temperature was 99°. The "rub" was confirmed next morning by two observers, but not by the rest of those who examined her. She was placid and of good colour. The case proved fatal.

(For Solution see Clinical Lecture by Dr. Fawcett, May 6th.)

An Incompatible Mixture.

It is sometimes desired to give quinine with sodium salicylate as in the following mixture :—

Sodium Salicylate - - -	15 grains.
Iron and Quinine Citrate -	5 grains.
Water to - - - - - - -	1 oz.

Iron and quinine citrate, unlike iron and ammonium citrate and other "scale" compounds of iron, is decomposed by salicylates, and in this mixture insoluble quinine salicylate is formed either as a very flakey precipitate or as a plastic mass, depending on the concentration of the solutions when mixed.

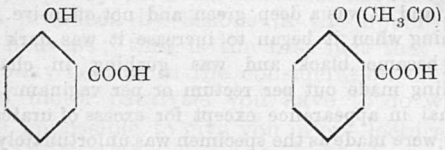
The formation of a precipitate in a mixture is not essentially a reason why they should not be prescribed together, provided that by shaking the substances are easily diffused through the mixture, and the patient is able to take a correct dose of all the ingredients.

These desiderata are not attained in the case before us. Various agents were tried to coat the solutions before mixing and so render the precipitate diffusible, and of these mucilage of acacia was found to answer best of all. To the solution of iron and quinine citrate a drachm of mucilage of acacia was added and then the solution of sodium salicylate, with vigorous stirring. No precipitate subsided in this mixture even after standing a fortnight.

H. F.

Further Note on Aspirin.

This substance is chemically acetyl-salicylic acid, and its relation to salicylic acid is shown by these formulæ :—



Salicylic Acid. Acetyl-salicylic Acid.

from which it is seen that the hydrogen of the phenolic group (OH) is replaced by the radicle acetyl (CH_3CO).

It may be made from salicylic acid by the action of acetic anhydride according to this equation :—

$$C_6H_4\,(OH)\,COOH + (CH_3CO)_2O = C_6H_4O\,(CH_3CO)\,COOH + CH_3COOH.$$

(Salicylic Acid) (Acetic Anhydride) (Acetyl-salicylic Acid) (Acetic Acid)

It is easily distinguished from salicylic acid by means of ferric chloride, this reagent yielding a purple colour with salicylic acid, but only a faint red colour with acetyl-salicylic acid.

It is easily hydrolysed, forming salicylic acid, and this acid would most probably be formed in the system and excreted in the urine. This fact should be borne in mind when testing urine for aceto-acetic acid with ferric chloride, or for blood by means of ozonic ether and guaiacum tincture.

Pharmacy.—As this substance is somewhat deliquescent, it is not suitable to order it in powders. It is not very soluble in water (1 part in 100) so it should be suspended and 1 grain of tragacanth or 1 drachm of tragacanth mucilage to one ounce of water appears most suitable.

It may be given in a soluble form by the addition of sodium bicarbonate as forming the sodium salt, but it should not be ordered with the excess of the bicarbonate, as this would cause the feebly held acetyl radicle to be split off.

H. F.

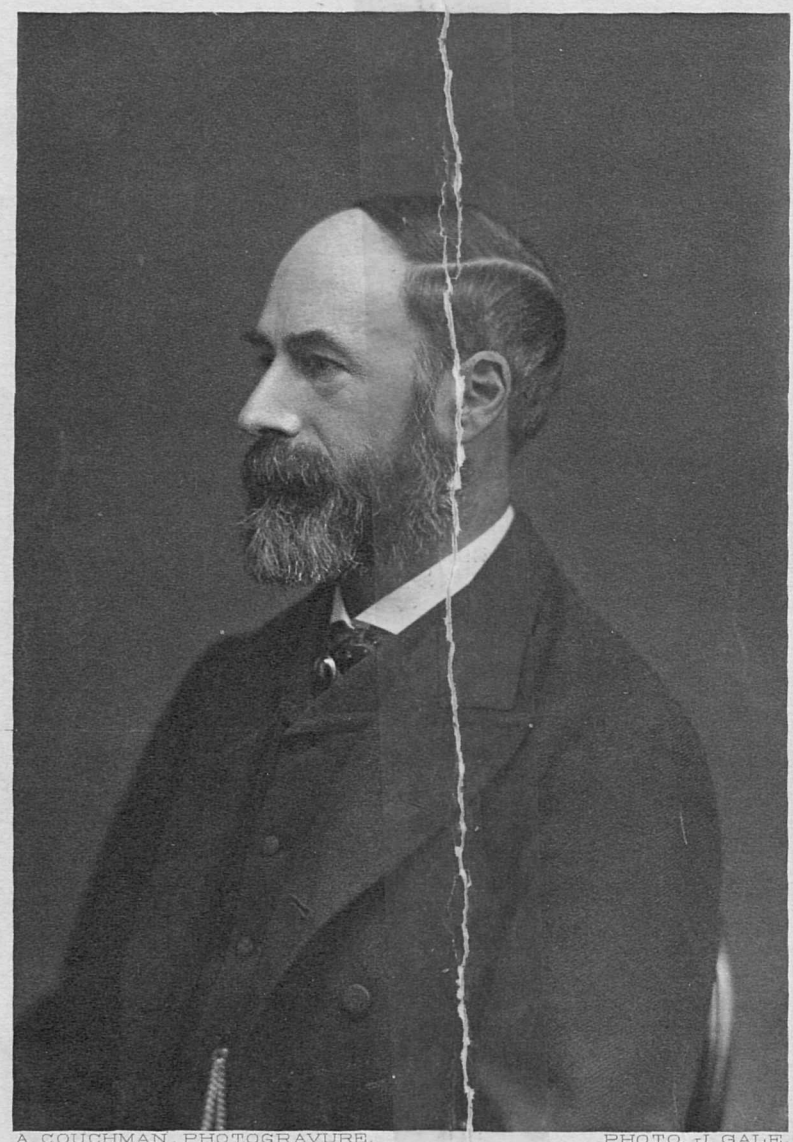
Guy's Hospital Clubs' Union.

The following donations towards the funds of the Clubs' Union have been received :—

	£	s.	d.
H. C. O. Bonsor, Esq.	10	0	0
R. E. Johnston, Esq.	5	5	0
Sir R. Harrison	2	2	0
Dr. Pavy	2	2	0
Sir S. Wilks	1	1	0
C. Higgins, Esq.	5	5	0
Dr. L. E. Shaw	3	3	0
Dr. Savage	2	2	0
Dr. Stevenson	1	1	0
Professor Reinold	1	1	0
Dr. Beddard	1	1	0
C. H. Fagge, Esq.	1	1	0
R. P. Rowlands, Esq.	1	1	0
L. A. Dunn, Esq.	1	1	0
Dr. Fawcett	1	1	0
W. A. Maggs, Esq.	1	1	0
J. Lewin Payne, Esq.	1	1	0
J. H. Badcock, Esq.	1	1	0
Dr. Craig	1	1	0
E. B. Dowsett, Esq.	1	1	0
P. S. Campkin, Esq.	1	1	0

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.



A. COUCHMAN. PHOTOGRAVURE. PHOTO, J. GALE.

Yours Truly,

Alfred L Galabin

Passim.

The enclosed reproduction of the photograph of Dr. Galabin is an exact copy of the presentation portrait of himself now reposing in the Junior Charities' Room with Dr. Braxton Hicks and others. It is not the time nor the place to recapitulate the details of his hospital career nor to dwell upon his recognised position as an author or as a consultant and operator, because we hope he will for many years to come continue to play an active part in the profession, though he has since January resigned his work in Queen. It forms a companion to the portraits of Mr. Davies-Colley, Sir Henry Howse and Dr. Pye-Smith.

Mr. Beerbohm Tree has most handsomely and generously offered to give a performance in aid of Guy's Hospital this summer in place of the performance which had been promised, but was unavoidably postponed in the distress of the June of 1902. "Flodden Field" will be given at an evening performance at the end of May, and the play will be mounted and staged with that magnificence and success that we are accustomed to expect at His Majesty's. The play is a new venture by the Poet Laureate, and the novelty should prove very attractive and, we hope, remunerative.

At a recent inquest on a run-over case, the Coroner's officer declared that it was impossible to find out the facts as the constables' numbers were not even taken. This, as a matter of fact, is not true, as it has been the custom for years for all constables' numbers to be recorded in the book, but now a definite form has been arranged on which notice to the Coroner is to be given with spaces for such details to be filled in. It is much to be regretted that the Coroner's officer does not take the trouble to ascertain the facts properly before making such incorrect statements.

During the repairs and alterations in Old Mary preparatory to its taking over the male medical beds, a workman stepped backwards through a hole in the ceiling and was precipitated into Mary and rebounded with his head against the bath. In spite of the not inconsiderable height and the hardness of the floor, he was admitted into Astley Cooper practically not worse than shaken.

Our hearty congratulations to O'Brien and McEvedy on their play for Kent in the Final of the County Championship. McEvedy's try in the last few minutes as the result of some excellent passing received great approval from the onlookers. It is interesting to note that the London Scottish supplied the back, and two Irishmen—colonial-born—and two Welshmen the four three-quarter places in the Kent team.

The Cricket XI. have a somewhat ambitious programme to fulfil, and it can only be carried out by the members resolutely supporting their captain and secretary and at whatever personal inconvenience never scratching or failing to play. It used to be said in the old days before the Bridge invasion that there were but two reasons for not returning a trump lead at once—sudden death and not having any; and we hope that the members of the Guy's Cricket XI. will not fall short of so strict a devotion to their duty, but when called upon to play will respond with alacrity.

We are requested to call attention to the Past Match on June 20th, and do so with pleasure. It is earnestly hoped that members willing to play will communicate with F. J. Nicholls, who has kindly consented to get up the XI.

WHILE all the world slumbered some nights ago the porters and the acting Superintendent were experiencing the unwonted and unwelcome excitement of a fire alarm in the surgical buildings. The blaze occasioned by some wool started a chimney roaring merrily through some three storeys of surgical wards, and a shower of sparks, soot and dust was seen falling thickly on the roof.

ANIMATED by the archaic directions in case of fire the porter fled to seek the resident plumber and other workmen. The plumber's (?) voice was heard through the night air in the best trades union spirit declaring that it was not his business to put out chimneys but the carpenter's, whereat the porter with great acumen pointed out it was the plumber's business to turn on the water. A wet blanket or two easily solved the dilemma, and the amused and sleepy listeners to the excitement hurried to their repose once more. Not so the indefatigable Deputy Superintendent, exorted by the Night Sister, he toured the entire Hospital and inspected the chimneys while the rest slept on—"Oh the wild tour he made. All the world wondered."

SOME generous impulses were shred by the news that "Old Ben" was about with his bedridden wife to seek the seclusion and nursing of the Infirmary. For forty years he has been connected with the fortunes of the Guy's Cricket XI. and shared the notable triumphs as umpire and scorer, but latterly merely as spectator. Well past his eightieth year, we can only say that it is impossible to provide the nursing and attention he needs outside, and probably the best his friends can do for him is to look at him from time to time but to let him rest where he is.

THE meagre announcement that Captain Sime, of the Indian Medical Service, was cut off with the 200 men who were detached from Colonel Cobbe's column in Somaliland and is probably killed, we are afraid can only refer to Lieutenant F. W. Sime, I.M.S., who left England last year after being gazetted Lieutenant July 26th, 1902. A splendid all-round man of fine physique, we have no doubt that whether in the hardships of the campaign, or the difficulties of medical field service, or the massacre of the retreat, his behaviour was worthy of the respect and affection he was held in at Guy's.

Nursing News.

MATRON'S OFFICE.

On April 10th, Nurse Bennett left the Hospital on completion of her three years' training. Nurse Maddison, Head Nurse in the Isolation ward was appointed to succeed her as Head Nurse in Cornelius ward. Probationer Worthington was appointed Head Nurse in the Isolation wards.

On April 15th, Nurse Savage left the Hospital on completion of her three years' training, to take up her duties on the Private Nursing Staff. Probationer Medley was appointed to succeed her as Head Nurse in the Surgery.

On April 20th, Probationer Melia was appointed Head Nurse in Lydia ward.

On April 21st, Nurse Iszard left the Hospital on completion of her three years' training, and Probationer Foster was appointed to succeed her as Head Nurse in Mary ward.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

G. M. J., ALTON (marked No. 3).—The mammary tumour proves to be a small simple cyst, with a smooth wall and much indurated tissue around it. Under the microscope the wall is composed of laminated fibrous material without an epithelial lining, and there are *no* signs of malignant growth.

R. D. A., HERTFORD.—Tubercle bacilli were present in this specimen in small numbers.

PATHOLOGIST.

Dr. Galabin.

Dr. Galabin was educated first at Marlborough College, and went to Cambridge with an Open Scholarship to Trinity College. There he gained a Foundation Scholarship in the following year. He was ninth in the first class Classics, twenty-first Wrangler. He gained the Wrangham Gold Medal as being first class in Classics, first class in Mathematics, and first class in Every College Examination. Elected Fellow in 1868, studied Medicine at Cambridge, and entered Guy's 1869. He soon brought his mechanical knowledge to bear on his medical studies, and in the years 1870 and 1871 was much engaged with the sphygmograph (about which he had a controversy with Mr. Garrod), and the cardiograph, the interest of which was shared with the late Dr. Mahomed. Dr. Galabin invented a cardiograph, and contributed a paper upon it to the Guy's Hospital Reports.

He was appointed Assistant Obstetric Physician on the death of Dr. Phillips, in February, 1874, at the end of his house physiciancy.

Elected Fellow at the Royal College of Physicians in 1878 (recommended by the late Sir George Paget, Regius Professor of Medicine at Cambridge), the earliest election at which he was eligible, four years from date of membership.

He was many years Examiner to the Universities of Cambridge and Oxford, and also at the London University. He was appointed a second time to examine for the Third Examination for the M.B. Degree at Cambridge. This was unusual for a non-resident.

He retired under the age limit on January 7th, 1903, and though not visiting Queen he is as busily engaged in Bright with his private practice as ever, and we trust he has many years of success before him, though we believe he finds the relaxations of gardening in Devonshire very alluring.

Obituary.

Solomon Charles Smith.

M.R.C.S., L.S.A., M.R.C.P.

Dr. Solomon Charles Smith, late of Halifax, died at his residence, Four Oaks, Walton-on-Thames, aged 61.

The son of a doctor at Halifax, he was born and educated at Halifax, and afterwards at the Birmingham General Hospital, Paris, and Guy's. He practised for many years in Halitax after qualifying in 1863.

In 1892 he removed to London and practised in Baker Street, and in 1892 was admitted to the Membership of the Royal College of Physicians. He joined the editorial staff of the *British Medical Journal*, and subsequently till his death was joint editor of the *Hospital*.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Open Air and Phthisis.

Dear Sir,—Having read a very interesting lecture by Dr. Pitt in a recent issue of the Gazette, viz., "On the treatment of Patients with Consumption in the Open Air," I herewith venture a few remarks. Generally speaking, I find, with an individual average of four months' treatment, 76·4 per cent. of febrile cases become apyrexial, and respond to treatment in the course of fourteen or twenty-one days. Apyrexial cases with rapid pulse and feeble heart-sounds do badly, in other words, arrest or quiescence of the disease occurs in 31·8, improvement in 44·6, while in 36·6 per cent. no improvement occurs.

About 90 per cent. respond, so far as weight is concerned, and when increase of weight is steadily gained it denotes healthy metabolism and arrest of disease, whereas rapid laying on of weight (subcutaneous fat) is of doubtful advantage. When the disease is limited to one lobe and no cavity exists, quiescence is invariably attained. An arrested case of tuberculosis may remain quiescent for a number of years in the absence of septic conditions and a lowered resisting power.

Heitler, in searching the records of the Vienna Pathological Institute, found that out of 16,562 post-mortem examinations on supposed non-tubercular persons, 780 gave evidence of obsolete tubercular nodules. Nevertheless, I think, it is a little unwise to speak too readily of "cures," for the lay mind naturally grasps the word "cure" as being absolute, and it is no uncommon thing to find that many of these cases from being lulled into a state of false security, have grown careless, relapsed, and rapidly gone to the bad; whereas, viewing the case as an "arrested" one means that a routine life is followed, and the ultimate result is more likely to be good.

Dr. Gordon would have us believe that "soil" appears "*to exercise a subordinate influence on phthisis mortality* in Devonshire," and that "the difference of the average annual death-rates from phthisis in the rural sanitary districts of Devon could not be explained by differences in general sanitation, rainfall or soil, but were probably mainly due to differences in exposure to west and south-west winds."

In a disease like tuberculosis, the cause of which is so often very complex, there must of necessity be a certain degree of fallacy in accounting for its causation on one hypothesis. The real causation is, I think, due to persons shutting themselves up in their homes, and so hastening or bringing about morbid changes. As an example of this, phthisical conditions and tuberculous glands are found among the inhabitants of the higher Pyrenees and in parts of the mountainous districts of

Wales, where the women and children spend the greater part of the winter months in sunless, ill-ventilated tenements, often consisting simply of a combined living and sleeping room; whereas, the male population, who spend the greater part of the time in the fresh air, beyond an occasional attack of rheumatism, suffer little and show few or no signs of tuberculosis.

In speaking of the question of amusement, Dr. Pitt admits that it is a difficult one. Excitement or much discussion tends to raise the temperature in phthisical cases, and in Sanatoria it is no easy matter to find the happy medium for individual cases. The longer one is associated with the treatment of phthisis, the more one realises the force of Dr. Pitt's remark, viz., "There is a happy medium which must be adopted in each individual case."—Yours truly,

Bournemouth, March 8th, 1903. A. KINSEY-MORGAN.

Guy's Hospital Children's Christmas Tea Fund.

December 31st, 1902.

Dr. Receipts.	£	s.	d.
To Balance brought forward	63	0	0
„ Subscriptions	115	10	2½
„ Collection from Hospital Workmen	2	6	9
	£180	16	11½

Cr. Disbursements.	£	s.	d.	£	s.	d.
By Refreshments	31	9	4			
„ Toys, etc.	19	7	2			
„ Cinematograph	6	16	0			
„ Fees to Servants, Police, Postages, etc.	5	3	7½			
„ Printing and Stationery	2	6	6			
				65	2	7½
„ Special Donations—						
Guy's Hospital (to maintain a Cot)	25	0	0			
The Haven	20	0	0			
Maternity Samaritan Fund	15	0	0			
Ward Concerts	10	0	0			
				70	0	0
„ Balance Carried Forward—						
Reserve on Deposit	30	0	0			
Cash at Bankers	15	14	4			
				45	14	4
				£180	16	11½

Audited and found correct,

March 13th, 1903. CHAS. H. WELLS.

The John Tomes Prize has been awarded by the Royal College of Surgeons of England to Mr. Kenneth Weldon Goadby.

A Case of Head Injury, complicated by Pneumonia.

Master O., aged ten years, a schoolboy, was hit behind his right ear over the mastoid process by a cricket ball on July 17th, 1901. He was not concussed, had no vomiting, no headache, said he was all right, and went on playing for another ten minutes.

On the 26th, he complained of earache in his left ear (the opposite side to that on which he was hit); his temperature 102°. There was no deafness and no aural discharge.

27th. Temperature normal, and boy seemed all right again.

28th. Patient very deaf in both ears. He lay curled up in bed, sleeping soundly day and night, but could be roused and answered questions rationally. Temperature 102°. There was no aural discharge, and he complained of no headache. There was no cough; respirations were not hurried, and in fact his lungs, heart, and all organs seemed healthy.

30th. He continued in this state until 4 p.m., when I was sent for urgently as the boy's temperature was 105·8°. He was very trembly and twitchy, very deaf. very drowsy; there was some photophobia. No paralysis, no squint, no fits. As the case was considered to be possibly surgical, Mr. Fripp was asked to see the patient in consultation, and after examining him carefully he considered there was no indication for operation and thought the condition might possibly be due to sunstroke.

31st. Mr. Fripp again saw the patient, whose temperature was 105°. He was evidently very ill, and the nurse reported a convulsion during the night lasting ten minutes, during which the left arm and left leg chiefly were jerked. There was still photophobia. Mr. Fripp was inclined to think the condition was due to head injury, but suggested that Dr. Hale-White should be asked to see the case with a view to its further elucidation. Accordingly, Dr. Hale-White came down and confirmed the conditions described above, but in addition he found double optic neuritis, and a small patch of commencing pneumonia in the right upper lobe of the lung over the scapula. Dr. Hale-White thought the case was one of pneumococcal infection of the meninges of the brain and also of the lung, and gave a grave prognosis.

August 1st. Temperature 103°. Pneumonic patch slightly increased; patient very deaf. There was considerable photophobia.

2nd. Temperature dropped suddenly in the night to 97°. No photophobia to-day; patient less deaf. The pneumonia patch was quite dull and gave all the signs of solid lung. All reflexes normal. The boy had a motion during the night containing a mass of threadworms.

5th. The lung had apparently quite cleared. Hearing was improving, but a watch had to be held ½in. from either ear before it was heard.

11th. The patient had steadily improved until to-day, when his temperature was again 102°. He was twitchy, and again had intolerance of light, but next day this was better, and the boy slowly convalesced, and after a three months' holiday returned to school apparently quite well.

In the case described above, the first question was whether the hit behind the ear with a cricket ball had anything at all to do with the illness, as nine days had elapsed, and the boy at the time of the injury made no fuss about it. Deafness first came on in the opposite ear, and subsequently in both ears, so that one had to shout to make him hear.

The deafness, decided photophobia, and the left-sided convulsion evidently pointed to some brain lesion, which seemed confirmed by Dr. Hale-White finding double optic neuritis. The patch of pneumonia was throughout quite a small one, and with the exception of slightly accelerated breathing one would not have instinctively been directed to the lungs as the seat of a lesion. The crisis in temperature came five or seven days after the boy was taken ill, a point strongly in favour of the case being one of pneumonia, but a rise of temperature nine days after the crisis was again accompanied by photophobia.

Since writing the above report, the masters at the school have told me that the boy has never been the same since his illness, being very twitchy now about his eyes, and somewhat intellectually dull; so I think one may justly consider there was some cerebral lesion, complicated with pneumonia.

ARTHUR B. HUDSON, M.R.C.S., L.R.C.P.

Cobham, Surrey.

Commentary.—Firstly, it seems clear the blow was only accidentally associated with the disease.

Secondly, the case explains the great difficulty of distinguishing the coma and convulsions that often accompany pneumonia from pneumococcal meningitis.

Thirdly, the probability is that as there was clearly double optic neuritis the patient had pneumococcal invasion of the lungs and meninges, and this is supported by the fact that he is now inclined to iritis and is mentally dull.

Whether the meningeal irritation is a septicæmia process caused by the actual diffusion of pneumococci or a toxæmia is at present uncertain. It is now recognised that any severe pyrexia of bacterial origin may produce slight neuritis, but probably not so severe as in the present case.

Papers by Guy's Men.

Debate on Diabetic and Non-Diabetic Glycosuria. Dr. Hale White and Dr. Pavy.—*Clinical Journal*, April 22nd.

Guy's Hospital Debating Society.

"To one who to tradition clings,
This seems an awkward state of things;
But if to think it out you try,
It doesn't really signify."

It was the evening of Saturday, March 21st, and in the college rooms "there was a sound of oratory by night," for it was the Ladies' Night of the Debating Society.

The smoking room was full of fair ladies and Hyperion youth,—in fact no youth who was not Hyperion was permitted to cross the sacred threshold. The Society certainly owes a great debt of gratitude to Mr. Kenneth Black, of Wandsworth (late of Chelsea, and sometime of Bath), who as Prince of Pew Openers, rigidly excluded all undesirable characters—at great personal risk, so it would seem, for his subordinates on three separate occasions ejected their chief, who was rescued (luckily before any serious injuries had been inflicted) by sympathetic members of the Nursing Staff.

At 8 o'clock, amid loud cheering, the Society's President, Dr. Savage, took the chair, and the minutes of the previous meeting having been duly read and confirmed, the time came for the fatuous verbosity on the part of those desirous of cheap publicity, which curiously enough goes by the name of "question time." Its announcement was the signal, as might have been expected, for the almost immediate appearance of Mr. Percivale Bolus, of Bow Street, who proceeded at once to indulge in a most unwarranted personal attack on the Junior Secretary. The President's eye was seen to gleam professionally at the speaker—and from the presidential pocket a notebook of prodigious dimensions labelled neatly "Bedlam," was produced, and a few rapid entries made. When the diatribes of the Pernicious Percivale came to an end, and when that Red-Waistcoated Archaism retired to cover behind a friendly tea urn which graced the bar-counter in his immediate vicinity—then, and not till then did the Junior Secretary rise to his feet amid storms of applause, and proceed with that calm dignity which characterises all his utterances to the demolition of the Bewildered Bolus.

(We may mention here that the Presidential pocket-book was immediately closed and returned to its own place, when its owner saw who it was that was now speaking. Let us have no unfortunate confusion in the minds of our readers).

As far as we can recollect the Secretarial reply was as follows—appealing to the House in general, he said:—

What think ye then of foolish Percivale
And of the futile wheezes that he wheezed
From out the ale-slopped precincts of the bar,
Among the unaccompanied bachelors
And by the still, cold tea urns of the club.

And to the malcontent in particular he said:—"Percivale—Percivale, personalities are the last refuge of the futile."

Hardly had this well merited rebuke been administered when "High o'er the Bar leapt Sunny Mann" and demanded to know the occupation and exact whereabouts of the Senior Secretary, whom he most unceremoniously alluded to as the Gruesome Griff.

Had it not been that a telegram had just been handed to the President from the gentleman in question, this interruption would have been ignored, but seeing that the message was to the Society it was thought fit to read it at this juncture, even though it should appear that the officers of the Society were pandering to the childishness of the little fellow who had just caused so unseemly a disturbance.

The telegram was accordingly read. It came from Leicester, and was unpaid for. It ran as follows: "Sorry cannot be with you 2 H B F's to put on—urgently needed. Gr—f—n."

Two other telegrams were read, the first was from Leeds and ran as follows:—

"Love to ladies, cannot trust myself to come.
Rudie."

And the second from Colney Hatch:—

"With you in spirit. Aphasia improving.
Cerebrum."

The general "business" thus coming to an end, the President called upon Mr. James Brydone to propose "That this House rejoices that the Age of Chivalry is past."

Mr. Brydone, who spoke for a quarter of an hour, was like the old lady's dictionary—interesting but disconnected. He ran the whole gamut of available similes from the bones of the mighty dead, which he declared were mouldering though they could be neither seen nor felt—to a dead mackerel on a muddy foreshore, which could be both seen, felt and heard. He described chivalry as a mediæval excrescence, having its origin in error—owing its temporary existence to a fallacious estimate of the fair sex—and now as clearly dead and gone as the above-mentioned mackerel. And speaking of the mackerel it was a nice bird and had a kind face. Its face in fact was almost as kind as his own—from which nothing but a surgical operation could eradicate the smile. To that smile, he said, he owed numberless pleasing episodes which could not have happened to a man of a sterner cast of countenance. These experiences were nevertheless in keeping with the age in which we live—and happened every day though in a lesser degree to every man. Their possibility was a standing proof of the decay of the age of chivalry.

Mr. Wrench, who, as Mr. Wacher aptly remarked, was "a mediæval poem in himself," now arose, and, reclining with easy grace against a convenient pillar, spoke at some length on the age of chivalry, the passing of which he deplored in a few pregnant sentences. He was interrupted several times, but his only method of retaliation was to smile and cough, occasionally varying the process with a cough and a smile. He told us that the one great sorrow of his life was the fact that his hair was not red, for that debarred him from playing the part of a Rudolph Rassendyll. The exact bearing of this reflection upon the matter in hand was not quite obvious, but we believe it had some deep significance. Towards the end of the discourse Messrs. Brydone and Wacher bowed their heads, and Mr. Wrench burst into a triumphant pæan of praise.

"Ha, ha," he cried, "you bow your crests,
My eloquence hath set you weeping;
Your heads you bend upon your breasts—"
(And so they did for they were sleeping).

Mr. Wacher strongly reminded us of Mr. Daniel Leno. He told us that he was perhaps known best in his well-worn rôle, "The Agreeable Rattle," which he was now playing at the Canterbury. He had jotted down a few great thoughts in the train, and perhaps the girls might like to hear them. As far as smiling went, he thought he could give Mr. Brydone points in that; his was, perhaps, more of a sardonic smile, but that made him all the more interesting.

Mr. Penny declared that chivalry was not dead, it was positively in a flourishing condition, and nowhere was it more firmly rooted than in this hospital. He spoke of the devotion of the clergy for the Sisters (the Chaplain was seen to turn pinker), the tender solicitude of the students for the nurses (some of them), and of the abandoned passion of the Commissionaire for the scrubbers. Begging the House not to sneeze at him, he spoke of the moral declension of Mr. Brydone, who had been wont in his early youth to support the gentler sex, but was now turning and rending them. The Brydonic soul was degenerating and becoming lipomatous.

Mr. Myott made a few remarks on mediæval millinery. He told us that chivalry had fled with the advent of the plâquêt hole. In these days of the hat of a delicate flame pink, slashed with grey, and of the embonpoint côrsâge with its banal bolero, what was there left for a nervous man like himself to do. Amid the applause of the ladies, he sank back upon the proposition bench, flushing a delicate puce pink with green spots.

Mr. Edridge pushed a theological wheeze without any interruption. Possibly the quotation was not known to many. But from a child he has known the Jewish Scriptures, and is, we believe, an authority on the Prophet Haggai. He will preach in the Chapel on the 32nd of this month with the unqualified consent of the Chaplain.

Mr. Collins Lewis gave us a practical demonstration on "How to read South Eastern Placards upside down." He was wearing gold-rimmed spectacles.

The Chaplain hated above all things to encounter a sister. He looked ungainly on a bicycle, but was actuated by motives of chivalry none the less. (Snores.)

Mr. Watney, whose voice is very refined, rejoiced that the age of anthropomorphism was passed.

Mr. Black said, "Times change, and we with time, and so in ways of chivalry."

Mr. Hodgson was wearing a white waistcoat. He had been, he said, to a wedding, and would say no more. (Cheers.)

A Lady Visitor spoke briefly, inaudibly, but with great charm.

Sister Wheezes spoke amid cheers, screams, and laughter. She said, amongst other things:—

1. "Life is not worth living. I don't see anything funny in it, I call it very silly."
2. "There are no gentlemen in the Hospital. When I go out and meet *my* men friends, I realise what gentlemen are."
3. "Marie Corelli, 'the arch humorist of English literature,' has written a book called 'The Mighty Atom.'"
4. "The Hospital always stands first. I have my principles."
5. "I kant have it."

She stood with her head on one side, and her hands in her apron pockets.

The President spoke briefly before the replies of Messrs. Wrench and Brydone, which followed respectively (but not respectably) in due course.

The proposition was defeated by a swamping majority.

All the ladies adjourned for coffee—the society is bankrupt.

Appointments.

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants in Medical Wards.—Messrs. F. P. Hughes (Dr. Taylor); S. C. Bowle (Dr. Hale White); P. A. Peall (Dr. Perry).

Clinical Assistant in Surgical Wards.—Mr. P. R. Bolus (Mr. Symonds).

Ophthalmic Dressers.—Messrs. A. C. Osburn, K. Black (May 1st, Mr. Higgens); N. N. A. Houghton, H. C. Winckworth (May 1st, Mr. Brailey); H. Watts, J. B. Copland (June 16th, Mr. Higgens); R. A. Greeves (June 16th, Mr. Brailey).

Surgeons' Dressers.—Messrs. A. V. Maybury, G. Russell, C. P. Harvey, R. P. Rowlands, G. H. Cheyney (Mr. Lucas); C. J. S. Dismorr, F. Rogerson, F. Barnes, D. Isaacs, J. W. Barrionuevo (Mr. Golding-Bird); D. Bridger, F. W. M. Palmer, J. H. Clatworthy, J. M. Pollard, A. F. Hertz, W. M. Mollison (Mr. Jacobson); E. C. Myott, A. M. Benett, W. N. May, J. E. Prentis, E. W. Routley (Mr. Symonds).

Externs.—A. M. Webber, M. G. Louisson, M. J. Mottram, R. Franklin, O. V. Payne, G. A. Ticehurst (May); E. Lloyd, H. H. Carter, W. S. Orton, R. M. Rendall, H. H. Jenkins (June); P. P. Cole, J. Cook, J. D. Thomas, H. F. B. Walker, P. F. Minett, A. E. F. Kynaston (July).

CIVIL.

Pern, Lionel, L.R.C.P. Lond., M.R.C.S., has been appointed Assistant Medical Officer of the Wandsworth and Clapham Union Infirmary.

Reflections

(After reading notes of destitution and misery encountered by the Trained Nurses of Guy's Hospital Maternity Department).

Eighteenth Annual Report for year 1902.

O ye who mince and carp on troublous times,
On darkened lots, on hardened lines—
Whose heads are sheltered from the frosted rimes,
Nor hear dear children's hunger-whines:—
Listen and drink of words so simply giv'n
By good Samaritans who work
Where child and woman lack the light of heav'n
And hell's dark fingers deftly lurk.
The maid who magnifies the bitterness
Of cooling swain or lover lost;
Or she who toils as lonely governess,
And envies other women most,
Should read of "Little Tim." or, better, spend
A day in Bermondsey to a higher end!
No myth, no bluff romance will thrall her there,
No yellow-back-three-volume-make-believe,
But stern realities that humans bear,
And slums where children starve and women grieve.
Where neither wrap nor radiant air awaits
The unwilling imp ushered through Nature's gates
Where shallow cup or coarse unbottomed can
Serves the first toilet of the God-sent man.
Where bearing mothers groan 'neath tattered threads
And garments flimsy as their hopes,
Where shelves are bare, and bony Hunger treads,
And drunken Degradation gropes.
Nay, carp no more who think that ye have ills
Unbearable, but raise your eyes
To those who grovel on hell's window-sills
And still your unbecoming sighs
To ye who have the power of gold to give
And yet give not—may aught defend
Your score when the Recording Angels dive
Into the "mark-book" at The End.

Recent additions to the Dental Museum.

The jaws of the sargus and of the hare.
Mr. W. A. Maggs.

Specimen of a confluent rattlesnake.
Prof. F. E. Beddard.

A series of sections of a human mandible showing the relative position which the teeth and their roots occupy in the jaws. Mr. J. H. Badcock.

Sections of teeth cut so as to show the relative size, shape, and position of the pulp canals of the different teeth. Mr. J. H. Badcock.

A horizontal section of the maxilla showing the antral cavities. Mr. J. H. Badcock.

Incisors and canines removed from the mandible of a man. Each tooth has *two* definite pulp canals.
Mr. A. W. Walker.

Skiagram and models of the mouth of a woman æt. 30, in whom the upper temporary incisors and canines were persistent. In the maxillæ the permanent incisors and canines had not erupted and both the lower laterals and canines were absent from the mouth. The skiagram shows the upper permanent incisors embedded in the jaw and crowded together. Mr. J. W. Walton.

Models showing traumatic displacement of the upper incisor teeth. Mr. W. E. Griffin.

Models showing irregularity of the temporary teeth. Mr. J. A. Donald.

Model of the maxillæ of a girl æt. 20, whose arch is markedly contracted. The lateral incisors are situated immediately behind the central incisors. Mr. J. L. Payne.

A large mass of tartar, in which all the four lower incisors are embedded. Mr. Ross Wallis.

Models taken from the mouth of a man æt. 64, where signs of attrition are evident upon the teeth which remain in the front of the mouth. Mr. A. E. D. Prideaux.

Specimen showing absorption of a lower right second molar caused by an impacted wisdom tooth. Mr. P. Scott.

An upper premolar which was extracted on account of chronic periodentitis. The inflammation was set up by a gutta percha root filling which perforated the side of the tooth. Mr. J. E. Spiller.

Model of the maxillæ, showing extensive destruction of the hard and part of the soft palate from acquired syphilis. Mr. F. Newland-Pedley.

A case of syphilitic perforation of the palate in which considerable cicatrization has occurred in the soft tissues behind the cleft. Mr. J. L. Payne.

Model of a mandible showing a sarcomatous tumour in a man æt. 61. Mr. H. C. Visick.

Models of a case of chronic hypertrophy of the gum associated with the presence of a number of septic roots. Mr. J. L. Payne.

A modified "Gunning" splint. Mr. P. Scott.

Model of the upper jaw of an infant æt. 10 months, whose alveolus on the right side had been fractured by a fall. The central incision is shown displaced backwards towards the palate. Mr. J. L. Payne.

Model showing a right upper central incision rotated so that its lingual surface looks forward. Mr. H. C. Visick.

Models of a case of an unerupted right upper canine. The model of the maxillæ shows the tooth lying horizontally in the buccal sulcus, but completely covered by the gum. Mr. P. Scott.

A right upper wisdom tooth with a supernumerary geminated to it posteriorly. Mr. H. J. Fox.

Specimen showing gemination of the left temporary central incision to a supernumerary tooth. Mr. J. H. Badcock.

Model showing the condition of the mandible of a girl æt. 15, five years after the removal of a myeloid sarcoma from the right side. Mr. C. D. Wallis.

Specimens of a dilacerated upper lateral incisor and a malformed lower first premolar. Mr. W. A. Maggs.

Specimens of three-rooted and four-rooted lower molars. Mr. Ross Wallis.

A cabinet showing the materials used in the manufacture of artificial teeth. The Dental Manufacturing Company.

A cabinet showing the materials used in the manufacture of rubber for vulcanite plates. The Dental Manufacturing Company.

A series of models, illustrating the method of preparing the model for fitting a "Logan" crown. Mr. J. H. Badcock.

Models arranged to show the method of making an "all metal" molar crown. Mr. J. H. Badcock.

A series of models arranged to show the method of making a "banded amalgam" crown. Mr. J. H. Badcock.

A series of models illustrating the method of making a composite crown of platinum and porcelain. Mr. J. H. Badcock.

Sport.

Rugby Football.

The Rugby fifteen brought their season to a close on March 7th, by a victory over the London Irish by 12 points to 6.

Out of a total of 49 tries scored during the season, Alcock has proved the most prolific try getter, no fewer than 19 standing to his account. Morgan comes next with 12, which, considering he has only played in ten games, compared with Alcock's sixteen, is decidedly good. Our other try getters have been Orpen 5, McEvedy 4, O'Brien and Saunders 2 apiece, and Harrison, Ward, Thompson, Brown, and Willan, 1 each. Of the 16 placed goals, O'Brien has placed 7, Harrison 6, Tolhurst 2, and Morgan 1. O'Brien has two dropped goals to his credit. Free kicks have not been of much value as far as direct scoring is concerned, as no penalty goals have been kicked by our team, and only one has been succesful against us.

One of the most noticeable features of the season has been the small number of matches played, no fewer than six having been scratched for various reasons, and in the first three months of the season only eight matches were played. Another surprising fact is that thirty-two men have played for the 1st XV. during the course of the season, Milsom being the only man who has played in every match. O'Brien has played in every match except the Saturday when the United Hospitals played Blackheath. However, accidents have been the rule rather than the exception, especially among the outsiders.

Of course the principal feature of the season has been winning the cup, but as great, or perhaps an even greater achievement than this, and one which has not occurred before in the annals of the club, is that of defeating both

the 'Varsities on their own ground, and among our other performances that of the O.M.T.'s and London Scottish matches stand out pre-eminently. Among the black days which we can't expect to do without, the Old Leysians, Richmond, and our first encounter with Catford Bridge must be numbered.

The satisfaction in our successful season is tinged with a feeling of regret at the loss we shall sustain of our captain, O'Brien. His play, although unaccountably ignored by the powers that be, has been, as was fitting in his last year, better than ever before, and he has combined his capabilities as a leader with more than ordinary brilliance in the field of play. His place will indeed be hard to fill.

		Points. for	agnst	Guy's. goals	tries	Opponents goals	tries
Kensington ...	Won	25	—	2	6	—	—
Lennox	Won	8	3	1	1	—	1
Camb. Univ. ..	Won	8	—	1	1	—	—
Catford	Lost	—	11	—	—	2	1
Richmond ...	Lost	—	24	—	—	3	3
Bedford	Won	18	—	—	6	—	—
O.M.T.'s	Won	6	—	—	2	—	—
London Sc'ttish	Won	14	—	1	3	—	—
Old Leysians ...	Lost	10	18	2	—	3	1
Catford	Won	3	—	—	1	—	—
London Welsh	Won	5	3	1	—	—	1
R.I.E.C.	Lost	3	11	—	1	1	2
Oxford	Won	23	8	3	3	1	1
Kensington ...	Lost	—	13	—	—	2	1
Lennox	Won	11	—	1	2	—	—
London Irish ...	Won	12	6	2	1	—	2
St. Bart.'s ...	Won	24	3	3	3	—	1
St. Thomas's ...	Won	6	—	—	2	—	—
The London ...	Won	11	—	1	2	—	—

Won 14; lost 5; 187 points to 105.

A Criticism of the XV. on their Final Cup-tie Form.

Although perhaps to the disinterested spectator, the Rugby Final presented no exceptional features, yet to the Cup Tie habitué the game will rank as one of the best, if not the best final tie of recent years. Those of us who remember the ties of the last ten years will probably recall the finals of '93 and '98 as close rivals for the distinction, the former game, though it ended in defeat, because of the splendid exhibition of stubborn defence against heavy odds, and a brilliant three-quarter burst in the last ten minutes, the latter game because of the enthusiasm which hailed the return of "the Cup" to the Borough after eleven years' absence. As far as an exhibition of football went, neither ranked as high as this year's, which itself was far from being the best display our teams have given this season. But then who expected it to be? Cup Ties are notorious for their "levelling-up" propensities, and the most scientific combination is frequently upset by a few daring spirits on the opposing side, who are not content to be beaten "on form" alone; and the hundreds of enthusiasts who went down to Richmond last Wednesday week, went down to see their team win if they possibly could, by any means bar foul.

Perhaps the most striking feature of the game was the complete change that came over it after change of ends. Previous to that honours were quite easy, and the game somewhat scratchy, the style of both teams lacking finish. Both sides were perhaps over-anxious, and the strong wind blowing nearly directly down the ground, accounted for several blunders. But after half-time there was really only one side in it, and, though we say it as shouldn't, that side was Guy's. With the wind, the kicking of our backs, barring two rather weak drops at goal, was really excellent, Harrison in this respect, and despite a nasty smack early in the game, quite excelled himself, and London only once seriously threatened danger. That was when Gibson intercepted a pass in his own twenty-five, and got within fifteen yards of our goal line before being pulled down. The tackling all round was sound. From our point of view we only spotted two cases of London men being badly missed, but many excellent and even unexpected tackles were made. In fact, the levelness of our outsiders was a marked and very satisfactory feature all through. For the last two seasons now we have had to rely on a team, probably the lightest in England, playing first-class football. Yet we have achieved many notable victories, and that in spite of the fact that the forwards have never shown themselves overwhelmingly good. No, we well remember the time when we were praying for heavy forwards to win us back the cup, yet without them our team has proved that success can be attained, and to excellence in combination alone can it be ascribed. This is in no spirit of boasting, but as an incentive and to point a moral.

The two sets of forwards were very well matched. London were better in the loose, but our front rank neutralized this by getting the ball more often in the scrum and thus giving our backs many chances, and but for a little excess of zeal (as it seemed to us) on the part of the referee, they would have had still more. There were no shirkers in the scrum, and Saunders and Glendinning were prominent in the loose. Mention, too, must be made of Tolhurst's excellent place kick from the touch line. The London halves were a trifle too smart for Cutler's comfort when our forwards had the ball, but he quite got his own back in tackling them. O'Brien played his usual clear-headed game, his kicking being invariably accurate and well-timed. He struck us as sticking to the ball a trifle too long considering the strength and ability of our three-quarter line to make openings. As we have implied before, no three-quarter outshone the others, but all played a sound skilful game. Orpen's tackling was remarkable. It was not exactly Morgan's day, he actually fumbled one or two passes, and suffered a little from the unselfish attention of his opposing three-quarter, Sparrow. McEvedy was quite up to form and Alcock put in some of those enjoyable little bursts which we now always expect of him and him alone.

The 2nd XV., we are sorry to say, has not done as well as we hoped, but it has had bad luck in having frequent changes of captaincy, the team having been in the hands of three different captains at various times during the season.

In strong contrast to this, the 3rd XV. stands out as having had a remarkably successful season, having played 18 matches, winning 14 and losing 2, 2 matches being drawn, scoring 219 points to 70 against. This excellent result can only have been brought about through hard work and keenness on the part of the captain, L. Reynolds, to whom we offer our heartiest congratulations.

3rd XV.	For			Against		
	goals	tries	points	goals	tries	points
Merchant Taylors' Sch. 2nd ...	3	6	33	—	—	—
King's College Engineers 2nd	1 (Penalty)	2	9	1	1	8
Kensington 3rd	1	4	17	—	—	—
Kensington 3rd	—	—	—	—	—	—
London Hospital 3rd	2 (1 D.)	2	15	—	2	6
Old Charltonians "A"	2 (1 D.)	1	12	—	—	—
Dulwich College 2nd	2 (1 D.)	3	18	2	1	13
Wasps 3rd	1 (D.)	1	7	—	—	—
London Hospital 3rd	4	2	26	—	—	—
London & Westminster Bank 3rd	4	3	29	—	—	—
Tonbridge School 2nd	—	2	6	—	1	3
Blackheath School	2	2	16	—	—	—
London Welsh 3rd	—	2	6	—	—	—
Ealing "A"	1	1	8	—	—	—
Epsom College	—	—	—	3 (1 D.)	2	20
Dulwich College 2nd	—	1	3	—	3	9
Wasps 3rd	—	1	3	—	1	3
Old Charltonians "A"	2 (D.)	1	11	1	1	8

Won 14; drawn 2; lost 2; 219 points to 70.

Solution to Case for Diagnosis.

The abdominal tumour was thought to be an ovarian cyst, and a twisted pedicle was diagnosed. The tumour was found to consist of a double pyosalpinx, the distended tubes lying close together, each measuring about six inches in diameter, and filled with a thick creamy pus. The Fallopian tubes, as they came off from the uterus, were much thickened and twisted, passing outwards on the inferior aspect of the tumour in each case. The ovaries were cystic and enlarged, especially on the right side, forming part of the outer wall of each pyosalpinx. On removing the tubes a subperitoneal fibroid, four inches in diameter, with a twisted pedicle two inches long, was found lying in Douglas' pouch, forming the tumour which had been felt per vaginam in the posterior fornix. The uterus was small and atrophic.

Bacteriological report.—Cocci, indistinguishable from the gonococcus, were found microscopically in small numbers. Cultivations from the pus remained sterile after seventy-two hours' incubation at 37° C.

Points on pyosalpinx.—Long history of sterility with vague hypogastric pain gradually increasing in severity and resulting in acute trouble. Raised temperature. Disordered menstruation in the direction of scantiness pointing to probably diseased condition of ovaries rather than uterus. The fibroid had no clinical importance at all.

Appointments.

NAVAL.

Surgeon Gerald T. S. Sichel, F.R.C.S., has been permitted to withdraw from His Majesty's Naval Service with a gratuity.

PRESENTATION.

Mr. George Black, M.B., B.S. Lond., on leaving Hurstpierpoint, has been presented by his friends and patients with a cheque for £130 in recognition of his unselfish labour on behalf of the sick and suffering.

Births.

BROWN.—On April 7th, at Carlton House, Gloucester, the wife of Walter Brown, M.B., of a daughter.

BRYANT.—On April 13th, at St. Thomas's Street, the wife of J. H. Bryant, M.D., F.R.C.P., of a daughter.

JACKSON.—On the 22nd inst., at Ashfield Road, Cheadle, the wife of T. Leonard Jackson, M.B., of a daughter.

PIKE.—On April 16th, at Flush Cottage, Heckmondwike, Yorks., the wife of Norman H. Pike, M.B., B.S., of a son.

Marriage.

DISMORR—McAVOY.—On April 15th, at the Parish Church, Finchley, by the Rev. J. Jessop Teague (uncle of the bridegroom), Vicar of Exminster, assisted by the Rev. W. St. Hill Bourne, Vicar of the Parish, Henry Bertram Dismorr, M.R.C.S., L.R.C.P., of Wroughton, Wilts., son of Henry Dismorr, M.R.C.S., L.S.A., of Lewisham Park, S.E., to Ellen Laura, daughter of George McAvoy, of Cambridge.

Deaths.

KELLOCK.—On April 3rd, at 94, Stamford Hill, N., William Berry Kellock, M.D., F.R.C.S., aged 82.

SMITH.—On April 6th, Solomon C. Smith, M.D. Durh., M.R.C.P. Lond., at Walton-on-Thames, aged 61.

Ed.—J. M. B.

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Calendar of Coming Events.

May, 1903.

Sat. 9.—Messrs. Golding-Bird and Dunn's take-in; Dr., C. J. S. Dismorr; Cl., H. Tipping.
G.H.C.C., I., v. Beckenham, 11 a.m., home.
II., v. Old Charlton, 2 p.m., home.
G.H.L.T.C., I., v. Sidcup, home.

Mon. 11.—1.15 p.m., Clinical lecture by Mr. Targett.

Wed. 13.—1.30 p.m., Clinical lecture by Dr. Fawcett.
G.H.C.C., I., v. London County C.C., home.
II., v. Manor House School, away.

Thur. 14.—Messrs. Jacobson and Fripp's take-in; Drs., R. D. Bridger and A. F. Hertz; Cl., B. H. Wedd.

Fri. 15.—Probable date of Final Fellowship Exam.
1.15 p.m., Clinical lecture by Mr. Lane.

Sat. 16.—G.H.C.C., I., v. Wanderers, 11 a.m., home.
II., London Hospital "A," 2 p.m., Hale End.
III., Sevenoaks School, 2 p.m., Sevenoaks.
G.H.L.T.C., I., v. Redhill "A," Redhill.

Mon. 18.—1.15 p.m., Clinical lecture by Mr. Higgens.
G.H.C.C., I., v. M.C.C., 11 a.m., home.

Wed. 20.—1.30 p.m., Clinical lecture by Dr. Shaw.
G.H.C.C., I., v. Blue Mantles, 11 a.m., Tunbridge Wells.
II., v. London Hospital "A," 2 p.m., home.
G.H.L.T.C., I., v. Blackheath "A," Blackheath.

Thur. 21.—Messrs. Symonds and Stewart's take-in; Drs., E. C. Myott and A. M. Benett; Cl., N. I. Spriggs.

Fri. 22.—1.15 p.m., Clinical lecture by Mr. Lane.

Sat. 23.—G.H.C.C., I., v. R.I.E.C., 11 a.m., Cooper's Hill.
II., Old Olavians, 2 p.m., home.
III., Boro' Road College "A," 2 p.m., Isleworth.
G.H.L.T.C., I. v. Wanstead, home.

Guy's Hospital Gazette,

MAY 9, 1903.

Medical Evidence at Inquests.

BY the sending of their circular letter of March 16th, to all the London Hospitals (*vide The Lancet*, April 18th), the London County Council has—as far as such a public body will—confessed that its recent action in the appointment of a "Pathologist" and the behaviour of some coroners in the past few months in exclusively employing him, has been heterodox and most probably ineffective. It is obvious that the present condition of affairs cannot continue. At every inquest in some districts of South London the medical man is practically on his trial; he is not *subpœna*-ed to the inquest and receives no fee for his attendance, and yet is bound for his own defence to attend and justify his treatment of his patient.

The post-mortem examination in several cases has been made by an independent "expert" without the presence of the doctor, or without any account from him of the history of the patient's condition or illness immediately preceding his death.

We do not propose at the present time to discuss where such a state of things will lead to, but to make a few comments on the reply to the County Council by the Guy's Hospital Medical Committee, whose letter was published, in advance of all the other London Hospitals, in the same number of *The Lancet*.

As that journal pointed out, the Medical Committee took exactly the right line. They pointed out that in *cases of a special nature* (the italics are ours) they agreed that the services of a specially skilled pathologist were required; they were, however, strongly impressed by the fact that in many cases a safe conclusion could not be arrived at from the conditions found post-mortem alone, and that medical evidence as to the preceding illness was absolutely essential to a right judgment.

They also stated that it was obvious that in cases of sudden death or persons found dead, the attendance at the post-mortem examination,

and the evidence at the inquest of the medical man who first saw the corpse might be desirable. Finally while very willing to afford assistance in the furtherance of the objects of the Council, they were of the opinion that it was impossible to secure the services of pathologists of the required standard for the fee of two guineas. In this final paragraph lies the *crux* of the whole question. In this matter the County Council are inclined to economy. If the pathologists of the County Council are to be experts, the hospital cannot recommend anybody except he has been recently, or is one of the demonstrators in the post-mortem room, or lectures on some pathological or medico-legal subject to the Medical School. Members of the Staff who possess these qualifications for the post would not think of touching the work the County Council would press upon them at the suggested hopelessly inadequate fee. They are busy men, mostly Fellows of the College of Physicians, with a large amount of hospital and consultant work, and they could not possibly undertake the trouble and annoyance of constant inquests at that scale of remuneration. While many of the junior members of the Medical School Staff might be glad to take the fee offered, the members of the Medical Committee could not possibly recommend them to the County Council as expert pathologists of the required standard.

We understand that the medical committees of the hospitals met and discussed what reply should be given to this letter of the County Council. As far as we know St. Bartholomew's Hospital and Guy's Hospital are the only two who have unhesitatingly stood out against the proposals, two others are non-committal at present, and the other five have practically accepted the County Council's conditions verbatim. We cannot but think that the action of these latter is most lamentable. If they take the view that we do of the standard of an expert pathologist, they must know that he cannot be found to do the work for two guineas. If they take a lower standard of knowledge as sufficient we must say that we think they have underrated their responsibility in the matter. We can only hope that the firm attitude of St. Bartholomew's and Guy's may lead them to reconsider their conclusions.

The Medical Committee of Guy's Hospital was not asked for advice and consequently did not give any. In this case we think that a word or two as to what might be done may not be out of place.

Frankly, we do not think that for the great majority of post-mortems and inquests an expert pathologist is necessary. In cases of sudden death from heart failure, cerebral hæmorrhages, accidents, immersions, etc., the ordinary medical practitioner who is willing is quite competent to perform the autopsy.

There are we believe over three thousand inquests held annually in the Metropolitan area. If an expert pathologist is to be called upon to perform these autopsies at a fee adequate to his professional status, the cost to the ratepayers will be enormous and the result will not justify the means.

We do not believe also that any one pathologist attached to a coroner's district, as we suppose the County Council intends, is competent to deal with all the classes of medico-legal work which he may meet. One man cannot be an equal expert in toxicology, murderous assaults, gunshot wounds, or criminal abortion, to take a few samples. The Home Office does not employ only one expert for all its medico-legal work, but deputes the man most competent to undertake each particular case in question. We think that if four or five experts in the different branches of pathological and medico-legal work were appointed at adequate salaries, who could be called upon by the medical practitioner doing the post-mortem examination if the cause of death were not obvious—the expert most suited to the case being called in—the County Council would get the maximum of information at the minimum of expense, and would procure that information without embroiling itself with the whole medical profession by its lack of courtesy in snubbing and neglecting the most important witnesses at nearly all inquests—the doctors.

In any case, however, let there be public advertisement of the posts vacant for pathologists and open competition for them.

Some of the Later Results of Gastric Ulcer.

CLINICAL LECTURE BY MR. CHARTERS SYMONDS
March 18th, 1903.

GENTLEMEN,—We have at the present moment in the ward one of the patients considered amongst those of perforating gastric ulcer in the first lecture; and I propose to make her case the text for my remarks to-day, and to add notes of other cases which illustrate this particular subject. The patient is a girl 25 years of age, and three years have elapsed since the perforation. After the operation for perforating gastric ulcer, which was completed by flushing the abdominal cavity, and by mopping with gauze, without any drainage, she states that she remained quite well for some time. She is so accustomed to ill-health that she cannot exactly fix the date when she began to suffer again. I incline to think she has had indigestion more or less ever since. But she is clear that at Easter last year, or two years after the perforation, she had an attack of pain and vomiting, and was laid up for five weeks; and again in August of the same year, that is to say, last August. This attack was so severe that she fell down on account of the severity of the pain, and resembled her original attack of perforation. At Christmas of last year, which made the third attack in 1902, she again had sudden pain and was laid up. You will have noticed the periodicity of these attacks with the intervals of good health, and the patient says that during the attacks all food causes pain, and she is frequently sick. She obtains relief by lying in bed and doubling up her body and "pressing her knees into the centre of her stomach." The pain on these occasions is just a little to the left of the median line. The exact situation of the pain has a good deal of meaning; whether it is to the left of the middle line or to the right of it will help very much in localising the position of the ulcer. The pain is central and to the left, and she is very clear that in these attacks there is also pain at or about the end of the left clavicle. I would call your attention here to the loose statements frequently made by patients that the pain is "in the shoulder," but when enquired into carefully it is found to be about the end of the clavicle.

Another interesting point about her pain is that when severe it passes down the left arm to the fingers, and then backwards and forwards between here and the scapula. I have not noticed or elicited a history of pain in the left arm in any case of gastric ulcer; but I have several times known it in connection with duodenal ulcer, and have looked upon it as an important point in diagnosis. The pain will go down the inner side of the right arm to the internal condyle, and these patients will tell you that they wake at night and rub the internal condyle. I have noticed that markedly in two cases of duodenal ulcer. It is interesting to notice these little points, because we shall be able to tell you the condition of this patient's abdomen. When she came to see me last February, that is to say a month ago, she was comparatively free from pain. She could digest ordinary food, except vegetables. At present she looks pale and sallow. There are no obvious signs of dilatation of the stomach, that is, there is no splashing or peristalsis, but the gastric resonance extends higher up than normal. What is the cause of these symptoms? We have to notice these three marked attacks in 1902, resembling localised perforation of gastric ulcer, that variety which gives rise to pain and vomiting, but in which there is no extravation of gastric contents.

The attacks resembled this variety, not only in the suddenness of onset but in the prolonged pain and illness afterwards, and the perforation might have occurred in the old ulcer in the anterior wall, or in another ulcer on the posterior wall, either existing at the time of the perforation two years ago or since developed. The pain about the clavicle and in the arm suggested posterior wall.

The formation of an adhesion to the abdominal was another possibility. Adhesions will give rise to pain, varying in intensity, but I have not observed these severe attacks of colic. Pyloric spasm one has recognised in cases of duodenal ulcer; of stenosis from cicatrisation; of inflammation of the duodenum

from gall stones; and one can understand that interferences with the peristaltic waves by an adhesion might determine spasm.

Convinced that some relievable condition existed, I felt justified, in view of the successes that had attended my operations for this variety of gastric disease (36 out of 37) in urging the operation. This was carried out last week.

On opening the abdomen it was interesting, in the first place, to notice that the peritoneum was free from adhesions in all its parts, except in the immediate neighbourhood of the ulcer. That is to say, the extravasation of gastric contents and the handling and flushing had not led to the formation of adhesions. That was because boiled water was used, and no antiseptic fluid. The stomach was found to be a good deal dilated—an important point, because clinically we did not recognise this condition.

The site of the old gastric ulcer was marked by a flat scar, but not surrounded by any induration. The absence of induration indicated that the ulcer had soundly healed, that it had not relapsed, and that therefore it was not the cause of her pain. But we found attached to the scar a band, which passed upwards and was adherent to the diaphragm. It was about three inches long and from a half to three-quarters of an inch in diameter, and was quite soft. What was this band? You will remember that in my directions as to closing these gastric ulcers, I advised that we should lay over and attach a piece of great omentum. We found the great omentum attached to this site; and I think it very likely that this band was a free piece of this structure which had become ahherent to the under-surface of the diaphragm, or the adhesion may have been quite an accidental one due to the formation of organised lymph. The band was divided between two ligatures, and the lower end sewn down to the stomach to prevent recurrence.

No evidence of further ulceration being found the question arose, shall we now close the abdomen and dispense with a further operation? I thought what we had found was hardly a sufficient explanation for the severe periodic attacks. It will explain chronic indigestion; it will explain chronic pain, and it often has done so; but I was not familiar with it as a cause of definite periodic attacks like those of perforating gastric ulcer. Moreover, there is some evidence to shew that when gastric dilatation has reached a certain degree, pyloric circulation is interfered with and spasm results. Therefore, I thought it would be wiser to complete the case by performing gastro-enterostomy. I have not time now to go into the method of performing the operation, enough that a posterior gastro-enterostomy was performed by direct suture, with excision of a portion of the gastric wall. The patient is perfectly well and has had no untoward symptoms of any kind. It is quite open to criticism that the gastro-enterostomy was an unnecessary procedure; but from a considerable experience of its after-effects, one is quite confident that it gives rise to no disability in itself; that patients on whom it has been performed can eat ordinary food in the usual quantities, and that they are capable of full nourishment and hard work. We must wait to see the final results in this case. Judging from others the prospects are good.

My next case is a girl who was in the ward last year. She came up from Devonshire, and was 25 years of age. She gave a history of severe abdominal pain and profuse hæmorrhage from the stomach, as well as chronic ill-health. She had been under the care of a most careful physician, who on one occasion had to infuse saline, and he was convinced that unless something were done this girl would never do any good. You see in the synopsis that the chief symptoms she exhibited were chronic ill-health and hæmorrhage.

In this case we thought there existed an unhealed gastric ulcer, possibly with adhesions.

There was a most interesting condition in her case. The whole of the cardiac end of the stomach was closely adherent to the diaphragm and spleen so that it was impossible to divide the adhesions, and something else was necessary. Accordingly I performed a posterior gastro-enterostomy, using a Murphy's button. She recovered without any bad symptom at all. What good will gastro-enterostomy do in such a case?

In the peristaltic action of the stomach the wave starts from the cardiac end, and goes towards the pylorus. It appears that for some time the pyloric orifice remains closed, so that this peristaltic action is going on for some considerable time without any of the contents escaping; and one can only assume that she had an unhealed ulcer in the stomach, and as the peristaltic action went on this was dragged upon and caused her pain; or the adhesions themselves were dragged upon and determined the pain. Therefore an opening always patent will, I hope, diminished these particular causes of distress. I am not able to tell you the final result of this case, as sufficient time has not elapsed. You will at once learn as regards adhesions that some of them can be dealt with easily; in some division is impossible. One other point in connection with adhesions I might mention. Adhesions to a fixed point are much more important than those to a moveable point. Here I have shown you adhesions to a fixed point, the diaphragm. But there may be adhesions of the stomach to the liver, and the pylorus may adhere to the gall-bladder. These particular adhesions do not give rise to any great trouble, provided the mucous surface of the stomach is itself healthy and there be no stricture. If there be ulceration, the adhesions will increase the distress.

The next case is interesting, for it practically illustrates the whole history of this branch of surgery. The first operation I did upon this man was in 1893, before Murphy's button had been introduced, and before gastro-enterostomy was at all upon a secure basis. There are some points in the history of this man I want to dwell upon, because they will help you very much in making a diagnosis in these cases. He was forty-seven years of age when he came, and he gave a history of thirty years' pain and suffering, indeed, he said that he hardly remembers being free from pain, and even when a boy he had special attention paid to his diet. I want to dwell upon the pain this man had because it was at the time new to me. I have met with it since, but I do not think the peculiar symptoms of which he complained are fully recognised as belonging to these gastric adhesions. The medical man who sent him to me wrote: "I send him to you for attacks of pain. These are severe; he rolls on the floor in agony, and they will often last several hours." The history contains accounts of attacks of pain at various times. The attack began with flatulence and eructations; then he had pain in the pit of the stomach. As it increased in intensity it worked to the right, and then was felt with greatest force underneath the right ribs. After lasting a variable time, it might be hours, this pain ceased suddenly with a loud gurgle, and he felt as if a great load were taken off his stomach. He was quite exact and definite as to the situation of the pain, and also as to its intensity, and to demonstrate its situation he placed his fingers under the ribs exactly in the position of the gall-bladder. Three of these attacks had been witnessed by Dr. Phipps, who sent him to me. They were severe enough to demand the administration of morphia. Another feature of great importance was the absence of sickness. It was thought that a lump could be felt in the region of the gall bladder, but that I could not confirm. He had an attack the day before I saw him, and there was marked tenderness in the position of the gall bladder. You know that in hepatic colic, in the absence of jaundice, one of the most important symptoms, almost the clinching one, is tenderness abiding in the situation of the gall bladder after the first acute attack has passed.

During all these years this man had been under medical care, and he had ultimately been advised by a well-known physician in London to give up his business, which was that of a wine merchant, and to take voyages. Finally he went into the country, lived on a farm, and hunted a great deal; he was in typical good health, and without a spare ounce of flesh about him. He ate very sparingly, and of course could not understand why he should have all this pain. The leading points of his case are these; recurrent attacks of pain with free intervals, which had all the clinical signs of a gall-stone attack. I cut down upon the gall-bladder, hoping to find a stone in the cystic duct. You see it could not have been in the common duct, because the man had never had

jaundice. The gall-bladder was perfectly healthy; but in the situation of the pylorus were numerous adhesions. In those days we were not prepared for gastro-enterostomy, and the abdomen was closed. The effect was very disastrous; the man was worse than ever, and he began to be sick. Evidently the handling of the part had set up some fresh adhesions, and had finally closed his pylorus. He then, fortunately, came under the observation of a very distinguished physician, Dr. Thomas Walker, of Peterborough. Dr. Walker made the interesting observation that in the vomit which he examined there was some material which the man must have taken forty-eight hours before. And on this ground, with other signs which are very carefully described in the long communication which he sent to me, he thought that the man had gastric dilatation, and that an operation had better be performed. We examined him again for gastric dilatation, but none of us could come to the conclusion that it existed. There was no peristaltic action to be seen at any time.

I then opened the abdomen, and found adhesions closely binding down the pylorus and duodenum. At that time the operation of dilatation of the pylorus was in vogue, and I attempted to perform this operation. The opening of the pylorus was only big enough to take a pair of small Wells' forceps. In attempting to enlarge it, the duodenum was torn through into the peritoneal cavity. That had to be sewn up, and it finally closed the pylorus, and therefore it was only possible to give relief by gastro-enterostomy. In those days the only method we had commanding any great safety, was by using decalcified bone plates (Senn's). This operation was performed, and the result was beyond everybody's expectation. He got perfectly well. Within a fortnight he could eat beefsteak, and was better than he had ever been in his life. Unfortunately, within five weeks his symptoms began to return, the opening had evidently closed. He came back, and I repeated this operation with the plates, taking care to sew the mucous membrane over, and again the opening closed. So one felt that these plates were not sufficiently good for this form of ailment. I had used the bone plates for cancer before that time, and with success; but it was clear that in those cases which are not cancerous, with a tendency to adhesion, you must have something better than the Senn's plate; and it became a question what one should do for this man. Just at that time an old pupil of this school, an old friend of mine, F. T. Paul, of Liverpool, had made the suggestion that, as closure occurred with plates, a piece of the gastric wall should be removed by pressure. He designed two bone plates, not decalcified, which were to be placed one in the stomach and one in the intestine, to be tied together, so that they would slough through, trusting that the peritoneal adhesions formed during that process, would prevent extravasation into the peritoneum. I wrote to Paul, saying I had a difficulty in a case, and asked him to let me have some of his plates. He sent me up some, but the plan did not commend itself to me at all, and I thought it carried too much risk.

I proposed to incise along the adherent part, enlarge the opening, and suture. The adhesion when exposed was insufficient; the intestine was detached from the stomach, and presented two large irregular openings. It being impossible to suture such an opening, about two inches of the bowel were resected. Then a portion of the gastric wall was removed, for the entire thickness, leaving an aperature one and a quarter inches in diameter. Into this the distal portion of the bowel was sutured by continuous suture. Then the proximal portion was connected with the distal some three inches from the stomach. The diagram represents the resulting condition of the parts; there is, as you see a T-shaped junction.

I am glad to say that opening has remained patent and the man is well to-day. That is an operation which is recommended even now by some surgeons. It is, however, wholly unnecessary when the ordinary operation is possible, and therefore not justified. I had to do it once, unhappily, in another patient, because certain adhesions arose, and again it succeeded admirably. I want you to remember about this man, that a special feature of the case is the resemblance of the attacks to those of gall stones. The study of this case has helped me since

1893 in the diagnosis of a good many others. Perhaps I may refer to one which was very disappointing, although a surgical success. It was that of a lady who for twenty-six years had had attacks of colic. Everybody thought the cause was gall-stones. Having had the experience of Armstrong's case, I thought hers might be one of those curious cases of stenosis of the pylorus, because she had never had pronounced jaundice, although she had had slight jaundice. Moreover, I think you will find that gall-stone cases very rarely go on for twenty-six years having attacks. In such cases something happens before that time has elapsed; the gall-bladder contracts, or the stone becomes fixed, or the stones ulcerate from the gall-bladder into the duodenum or the colon and disappear; or they pass down the common duct and get away; or they form a large tumour, like the woman we have operated upon in Lydia, which is obviously gall-bladder. But I do not find they go on for twenty-six years. Armstrong's case was fresh in my mind, and I operated and found an enormous induration in the centre of her stomach, practically dividing it into two. This we thought was a malignant growth. Gastro-enterostomy was performed by direct suture. She was doing very well when on the sixth day she died in twelve hours from hæmorrhage. There was found an old simple ulcer with great induration, and in the floor the vessel from which she had bled to death.

I shall have to omit the narration of another case which interests me, because I want to leave you with the special features of each case to help you in your work.

Case 4 was in Job ward. He was a man æt. 32, and had pain for a year and vomiting for eight months. He had lost three stone in weight when he came in, and was exceedingly thin. I shall never forget this man the day before the operation. He vomited one of those ward basins three parts full of black fluid; he had, in addition, marked peristaltic action, marked dilatation of the stomach, and a large mass in the position of the pylorus.

At the operation next day he vomited again large quantities of this black material. Fortunately it took place before the stomach was opened, so I was able to squeeze the stomach and so assist him in emptying it.

The pyloric lump was large and nodular, and it apparently occupied the whole of the pylorus, and there were enlarged glands in the great omentum and in the gastro-hepatic omentum. The mass was moveable, and I thought it would therefore be favourable for excision after recovery from the gastro-enterostomy. The man did very well, and three weeks afterwards I re-opened the abdomen, my object being to carry out pylorectomy. But the lump had now become quite small, and I thought possibly it was a case in which the enlargement of a cancerous lump had been increased by accessory inflammation from irritation, and that the subsidence of that factor would account for the diminution in size; or it might be a case of a simple induration from an ulcer. One noticed that the gastro-hepatic omentum was thick and white, and on opening the lesser bag to examine the posterior aspect the mass was found adherent to the posterior wall of the abdomen. If it were carcinoma, that made excision impossible, but I thought it was simple and that he would get well. That was in 1900, and only three days ago the man wrote to say that he has never been so well in his life. He is able to eat anything and do anything, and he is earning his living. This is a case closely resembling gastric cancer, in the vomiting, peristalsis, emaciation, and the presence of a large pyloric mass, and the vomiting of black fluid.

Case 5 was a hump-backed and emaciated woman of 57; she vomited, had a large stomach, there was marked peristalsis, and one could feel a big central lump, which was apparently cancer. On opening the abdomen the mass occupied the whole of the pyloric area, but close underneath it there was a little line of yellow lymph, indicating recent peritonitis and perforation, and therefore, probably not carcinoma. The stomach and duodenum were adherent to the liver and to the gall-bladder. A posterior gastro-enterostomy was performed. That was one and a half years ago. I saw the old lady six weeks ago, when she was in perfect health. She had put on much flesh, and said she was quite well, and the large mass had disappeared.

That was an instance of a large indurated mass due to an ulcer in the pylorus. This ulcer had perforated only a few days before the operation. I was careful not to disturb these adhesions, with the result that the patient got quite well.

Let us now review these cases first as to diagnosis. The resemblance of some cases to gall-stone effects was well exemplified by a case brought by my old and lamented friend, George De'ath of Buckingham.

This man had had three attacks of abdominal pain, the third attack having been complicated by a little fever. The attacks were fairly typical of gall-stones in their suddenness of onset. There was also a good deal of stomach disturbance, with vomiting, suggesting the type of gastric case I have related to you. We could not be quite sure of the diagnosis; there had never been any jaundice, and there had not been any tenderness until the third attack, when this was present in the region of the gall-bladder. The gall-bladder was full of stones, it was deeply congested, and lay upon the wall of the duodenum, to which it was adherent, and that wall was inflamed. I take it that during his attack the inflammation of the duodenum set up paralysis of this portion,—a dynamic paralysis,—and gave rise to gastric distension, and symptoms of pyloric obstruction.

That is not a new observation. Halstead has published an interesting case of the same type, showing that you may get these symptoms of pyloric obstruction due to the gall-bladder; and that justifies me in bringing the point before you. I want you to notice under case No. 2 the absence of dilatation. When dilatation is obvious the diagnosis is easy; but when absent it may be very difficult. You may have almost complete obstruction of the pylorus without any clinical evidence of dilatation and yet find dilatation present at the operation. That is to say, you find a stomach like that of the girl I demonstrated in Lydia ward, in which it is wider than usual and comes out freely into the wound. It is difficult to diagnose the cases represented by No. 3, and to separate cases of old gastric ulcer from those of malignant disease. I have given you cases of this kind under Nos. 4 and 5. But if you go carefully over the history of these cases in which the resemblance is close, you will notice that spasmodic pain is present in the simple conditions, but is absent in growth. I do not think you will find spasmodic pain present in growth. Notice also the very close resemblance to growth at the time of operation. I think that is very important indeed.

What is the treatment best suited for these various conditions? In the cases where there are band-like adhesions, as is case 1, divisions may be sufficient, where there are broad and close adhesions, as in case 2, you must do gastro-enterostomy. Where there are pyloric and duodenal adhesions the course of procedure is a matter about which there is a great deal of difference of opinion. There are some who say that the best thing is to divide the pylorus and duodenum, and enlarge the opening. In other words pyloraphy. That is the operation advocated by some for these old effects of gastric ulcer in the neighbourhood of the pylorus. I do not think it is the best operation, and for this very good reason, that you cannot tell at the moment of the operation whether the ulcer is healed or not. In disturbing adhesions to perform this operation you may disturb the floor of the ulcer and determine a fatal hæmorrhage. I think that is a very good reason against the operation. It happened to me in one of my cases.

In another instance in this hospital, the man had practically recovered, but he died on the sixth day, of hæmatemesis, from the gastro-duodenal artery in the floor of the ulcer. If I had performed gastro-enterostomy, I should probably have saved him. Therefore, I hold strongly that of the two proceedings which are suitable for stenosis of the pylorus as a result of this cicatrisation, the one to choose is posterior gastro-enterostomy. It is always right, the after-effects are quite satisfactory, it can be done as quickly as the other, and I should say that, on the whole, it is much easier.

There is a tendency in these old cicatricial cases for the gastro-enterostomy opening to close unless a portion of the stomach wall is removed.

In the case forming the text of this lecture you will have noticed that a portion of the entire thickness of the stomach wall was removed, and

to the margins of the openings the small intestine was attached by continuous silk suture. This plan is satisfactory, and I have employed it on a good many occasions.

Murphy's button removes a piece of the wall of each viscus, and after its use I have not seen closure of the opening. Removal of a portion of the wall I employed before the introduction of Murphy's button. The piece should measure one inch by three-quarters at least.

If a piece be not removed then the opening must be a large one.

I have notes of thirty-eight operations for adhesions, cicatricial stenosis, and dilatation. Most of these were gastro-enterostomies, the rest pylorraphies.

In one pylorraphy the symptoms returned in a year. The man was thirty-two years of age, and there was no cicatricial condition, but apparently simple dilatation with wasting. A gastro-enterostomy was then performed, and he remains well and is able to do all his work and has gained two stone in weight. Of the thirty-eight operations there is one failure—a death from shock—*i.e.*, one death directly due to operation. This was a difficult case of stenosis of the pylorus and duodenum, upon which pylorraphy was performed. I should now never undertake this operation, gastro-enterostomy gives better results.

You will note that three cases died from hæmorrhage at varying periods after operation. In two this was probably accidental, in one it was probably determined by disturbing adhesions. As to its being accidental, I can recall two patients who died, the one three days, and the other one day, before that fixed for operation, both duodenal ulcers.

As an alternative to gastro-enterostomy in dilatation I must mention "plication." Once only have I performed this operation, and the adhesion resulting gave rise to great increase in the symptoms, subsequently relieved by gastro-enterostomy.

In conclusion, then, I would say that the best operation (in my experience) is posterior gastro-enterostomy for dilatation, and all pyloric and duodenal ulcers and stenoses. You will note that there is no death from peritonitis, so that the operation may be looked upon as one carrying comparatively little risk. When I come to speak of malignant disease, we shall find a serious mortality in advanced disease.

In the Surgical Wards.

Two Cases of Anthrax in Samaritan Ward.—One now Recovering without Operation.

(I.) H. G., æt. 44 years, a stoutly-built man, a dock labourer by trade. He had lately been unloading cases of tinned fruits.

Nine years previously he had been treated for ten months as an out-patient for a poisoned arm, and for the last year or so had been subject to boils.

On February 23rd a small boil was noticed at the angle of the jaw on the right side. On the 25th his wife poulticed it, and two days later he came up to the front surgery. On Sunday, March 1st, his face began to swell considerably, and he again came to the surgery. The house-physician on duty thought there was a danger of œdema of the glottis, and sent the patient into Samaritan ward.

On admission, there was a soft puffy swelling involving the whole of the right side of the face and neck, the right eye being completely closed. The swelling did not cross the middle line. There was little redness. At the angle of the jaw was the boil which had been poulticed.

The case was taken to be one of ordinary cellulitis. In the evening, as the temperature had risen 101°, two incisions were made and a considerable quantity of thin fluid escaped. Hot boracic fomentations were applied.

The following morning, March 2nd, the patient was much better, but later complained of great weakness, headache and giddiness. His pulse was rapid. On changing the fomentations a vesicular patch was noticed alongside the wound. This was thought to be due to the hot fomentations. At 6 p.m. the temperature had risen to 102°, the pulse being 128, and the respirations 28 per minute.

On March 3rd, the temperature at 6 a.m. had fallen to 99°, the pulse and respiration were unchanged. The giddiness still continued. Patient was ordered some brandy. At 2 p.m. he had a shivering fit which lasted for about twenty minutes. Half an hour later the temperature was 98°. The pulse was irregular, the voice weak and the patient somewhat comatose. He was ordered some strychnine and digitalis. At 6 p.m. the temperature had fallen to 96° whilst the pulse was still about 128, but too weak to be counted accurately. A small pustule was noticed on the man's hand. At 8.45 p.m. a severe attack of dyspnœa came on; oxygen and bronchitis kettle were used with some effect, but one or two more attacks occurred before death at 11.15 p.m.

At the autopsy the heart-muscle was found to be flabby. There was œdema of the right side of the larynx. In

the stomach were found seven ulcers varying in size from one-eighth to half an inch. These ulcers were shallow, with a sloughy and pigmented base and a surrounding inflamed area. The edges were not undermined.

In the duodenum there was much submucous ecchymosis. Twelve more ulcers were found in the large and small intestines. The mesenteric glands were enlarged. The spleen was soft and slightly enlarged.

From the character of the ulceration, taken with the rapidity of death, anthrax was suspected, and a film preparation made from the wound in the neck. Anthrax bacilli were found, as also in cultivations made from, (i.) mesenteric gland, (ii.) parotid, (iii.) ulcer from stomach and from colon, (iv.) blood from the heart. A guinea-pig inoculated subcutaneously by Dr. Eyre with 5 c.c. heart-blood died in twenty-six hours from typical anthrax septicæmia, with serous effusion at the seat of inoculation and anthrax bacilli in all the organs. Anthrax bacilli were also found in sections of the kidney and lung.

Later enquiries failed to bring to light any definite source of infection. Some of the tinned fruits had been packed with rice-husks, and some of the cases had been bound with strips of hide about half an inch in diameter. It was suggested that these cases might have become contaminated by a lighter in which infected hides had previously been carried.

(II.) E. S., æt. 36½ years, a strong, healthy-looking man, a dock labourer, who had been handling sacks of potatoes. He first noticed a small pimple on Tuesday, April 7th, and came to the Front Surgery on April 11th. He came again on April 15th, at about 2 a.m., and was admitted into Samaritan ward.

On admission there was a brownish-black eschar below the angle of the jaw on the right side. This measured one by one and a half inches, and was surrounded on one side by a ring of vesicles. The right side of the face was scarcely swollen, but there was extensive swelling of the front of the neck, and the whole of the front of the thorax and abdomen was œdematous down to half-way between umbilicus and pubes. In front of the neck were several blebs.

Film preparations from the eschar were crowded with anthrax bacilli, and a preparation from one of the blebs showed a few bacilli.

The general condition of the patient was good, the temperature was 98° F., the pulse-rate 82, and the respirations 22 per minute. Raising himself in bed sent the patient's pulse rate up to 100. Considering the wide-spread area of infection, it was thought inadvisable to run the risk of setting up bronchitis from an anæsthetic, and so possibly helping on pulmonary anthrax. The surface of the eschar was picked off as far as possible, and pure carbolic acid rubbed well in. Powdered ipecacuanha was put on, and creolin fomentations ordered every four hours.

The patient was ordered a diet with as much meat as he would take, and a mixture of—

Vinum Ipecac.	...	ɱxxx.
Mist. Quininæ ad	...	ʒi., 4tis. horis.

At 6 a.m. the temperature had risen to 101°, and by 10 p.m. to 102°, but the pulse rate was only 106. The following morning the temperature was 98°.

It was found necessary to give hypnol on the night of 15th and the two succeeding nights.

The patient progressed favourably until the 17th, when he was noticed to be rather grumpy, and to make objections to the fomentations being changed. He also would not take his food so well. The œdema had spread slightly into the right upper arm.

On the 18th (*i.e.* eleven days after inoculation) at 6 a.m. he was quite delirious, sitting up in bed and continually talking nonsense in a loud voice. He was ordered an I.M.H. gr. ¼, and some stimulant to be taken later. After a while he quieted down somewhat, but in the afternoon he had to be removed to the strong-room. On the 19th he was quite quiet. The same dressing was used every day up to April 28th.

After April 18th the œdema steadily decreased, and by the 22nd it had all disappeared except in the neck. May 5th, all threatening symptoms have disappeared, but some cutaneous sloughing of the neck is still coming away.

F. L. T.

A Note on the Treatment of Punctured Rubber-Dam.

AN accident that occasionally occurs in dental practice is the puncture or tearing of rubber-dam, which, being usually followed by a leakage of saliva, may give rise to much inconvenience.

Various methods are employed for dealing with this accident, but the majority of them give indifferent results.

A method which I have found very useful, and which has the advantage of being extremely simple, is the application of a small pair of Spencer Wells' forceps, one blade passing on either side of the hole in the rubber. This usually completely controls the leakage. If the forceps are in the way of the operator, a silk ligature may be passed around the rubber beyond the blades of the forceps, and the latter removed; this, however, is often unnecessary. In some cases Dieffenbach's forceps may be used in a similar manner with advantage.

J. E. SPILLER.

Appointments.

CIVIL.

KITCHIN, E. H., M.B., B.C. Cantab., has been appointed Medical Officer of the Skipton Union Workhouse.

Passim.

The Annual Report of achievements and position of Guy's Hospital, published by order of the Governors, is as always most interesting reading. The figures themselves are extremely instructive, and all Guy's men will do well to interest themselves to a considerable extent in the abundant food for reflection they afford. Thus the situation, taken briefly from an outside point of view, stands somewhat as follows. Guy's Hospital is a medical charity endowed by Guy in the first place, Hunt in the second, and countless benefactors in the past and present. The original endowments till 1880 were adequate to the demands of the poor in Southwark and the neighbourhood, but now owing greatly to the diminution of income by one-half due to agricultural depression are quite inadequate. The increase in working expenses has necessitated greater expenditure on medical and nursing necessaries, etc.

Some thirty years ago the income was £40,000 and balanced the expenditure, now the income from Endowments is £32,000, the expenditure £60,000. The in-patients number 8,091, the out-patients 124,963, and 3,712 confinements are attended in the homes. The mean mortality is 9·4 per cent. Guy's stands on rather more than seven acres of land.

Some facts of purely local interest may be found among the following:—485 beds are in daily occupation, and at least 5,600 operations are performed.

The number of accidents admitted seems to vary very little though it was rumoured that the street accidents were much less numerous than of yore. They number about 1000, and about 9 per cent. prove fatal. Probably the fact that the Accident wards are always kept full accounts for the admission rate being so constant, but the mortality being so constant is a little striking.

Bright, a ward temporarily opened for paying patients in the absence of funds to maintain it as a general ward, secures about £3000 a year as a rule, while the closure of the guinea beds involved a loss of about £1000 a year. Each bed costs about £100 a year to keep up. Each in-patient costs on the average six guineas, or, dividing without deductions the cost by the patients, nearly seven guineas.

The various alterations and improvements are also reported, but as most of these are familiar there is no necessity to reproduce them.

The Hospital still urgently needs £85,000 to re-complete the absolutely essential renovations of fabric; an additional endowment to produce at least another £20,000 a year, which will still leave a deficit; and for the present subscriptions to maintain the Wards as they are at present; and in the near future the Out-patient Department must be enlarged and re-modelled, the overcrowding down there is dreadfully unpleasant and injurious to the patients and us.

Amongst other points is the increase in the actual work done. The Medical and Surgical Out-patients' show an addition of nearly two thousand, but with this difference that while the number seen by the Assistant Physicians, in spite of an extra day's attendance, has diminished from seventeen hundred to twelve hundred in six years, the number seen by the two unfortunate House-Physicians has grown from six thousand to nine thousand in six years, and this is but new patients and takes no account of the old patients. On the other hand, the Assistant Surgeons have seen fourteen hundred more in 1902 than six years ago; while the four Assistant House-Surgeons see but an increase of five hundred on the two thousand seen by two House-Surgeons six years ago. Naturally the length of time required for any medical diagnosis accounts for the difference; as so many surgical diagnoses are obvious and can be dismissed at a glance.

In the Dental Department the figures are always large, eighteen thousand new patients attended and five thousand gases were given by six anæsthetists and their clerks.

WE were startled and surprised some three weeks ago by an enquiry from a British working man as to where he should put the South African Memorial. In the absence of the Secretary, we dutifully referred to the Minute Book, and there we found it duly recorded:—"Some discussion arose, and as some doubt exist as to the precise site of the Memorial, it was finally decided to erect it on the west wall of the Colonnade, on the south side of Cornelius." But doubt filled our minds in spite of this definite and authoritative utterance. The opposite side we ourselves had proclaimed to be the selected site, and on further enquiry we found it was to be so, though at what meeting and by whom the decision was amended, did not transpire till later, when the Hospital architect was found to have disallowed the proposal to touch the western wall, and therefore the other wall (quite as suitable, if not more so) was perforce chosen without further formalities. We then expected to see some dash displayed in its erection, but for the last three weeks since then the scheme has again slumbered. It is very dignified to delay, and in keeping with the best military traditions, but the war is beginning to fade from our memories and we feel that a Dedicatory Address will now be necessary to its unveiling.

IT is hoped that all Guy's men who can will arrange to be present at the congregation for conferring Degrees and Honours on June 24th at 9 p.m. Not only is this the first occasion on which degrees have been so conferred in the evening, but it is also the only occasion on which honorary degrees have ever been granted, and yet further and of more special interest still is the fact that among the distinguished recipients are numbered Lords Lister and Kelvin (most honoured names), and not least, His Royal Highness the Prince of Wales, President of Guy's Hospital. The fact that an honorary degree is to be conferred on Her Royal Highness the Princess is again an additional point of interest, and another reason why Guy's men should turn up and avail themselves of their privileges to do honour to the Prince and Princess whose interest in our hospital was so strikingly displayed last July. On another page will be found a notice from the Dean, but it is remarked that application must be sent off before May 16th, by special permission of the Principal.

WE were taken to task some time ago for saying that in our opinion the ordinary Conjoint man would be capable of doing satisfactorily ordinary post-mortems, and two interesting and actual cases were quoted to disprove this statement, *e.g.*, the early pneumonic signs and the early uræmic kidney. Our point was somewhat mixed, perhaps due to our own carelessness in expression, so we restate it and are prepared to stand by it.

THE vast majority of inquests are held on such deaths as ruptured aneurysm, fractured bases, and other fractures, over-lying and sudden death due to heart disease. We believe that the ordinary Conjoint man is perfectly capable of certifying to ruptured aneurysm, to the results of a fall or smash, and to the amount of evidence present to prove over-lying, and to heart disease. All poisonings, ptomaine or otherwise, all murders we need not consider, because the Home Office expert is called in, and even the Hospital pathologist, or any other pathologist's evidence is practically worth nothing where analysis is required, or medico-legal expert evidence is required

OUR point is this, that no report is complete without the general practitioner, and that for all cases of suspicion, like ptomaine poisoning or murder, a Home Office medico-legal expert and analyst is what is required, and not the advanced pathologist. In other words, the cause of death usually falls into one of two classes—the obvious cases—accidental death or death due to natural causes, which any general practitioner can recognise, or the obscure cases in which an actual medical specialist is required. If all post-mortems were done by hospital pathologists the system would be ideal, but the expense is not worth the increased advantage, as in the obscure cases the analyst and medico-legal expert, and even the bacteriologist, would equally be necessary for adequate conclusions. We do not believe that coroner's inquests often

fail to reveal any foul play, if there is any, though we cordially agree with the County Council that Coroners hold a great number of unnecessary inquests and order unnecessary post-mortems, because they will not consult the medical man on the point, preferring to delegate that delicate duty to an incompetent official.

It really seems extraordinary assurance on the part of the County Council to offer the pathological expert the same fee (two guineas) that the ordinary practitioner has a statutory right to demand. It, of course, does not affect the argument that a doubtfully competent pathologist, bacteriologist, analyst, and medico-legal expert was found among the acquaintances of the County Council officials to do the work for that fee, and as most hospitals have learnt by experience to do it very badly, and to produce some most astonishing conclusions that are quite incompatible with proved facts.

The proximity of the Hospital to the Leather District of Bermondsey has also given us an unique experience of anthrax, and the account of two cases under Mr. Fripp are most interesting, especially the result of the latter, who was considered too ill for operation on admission, as the extent was so great and his condition so bad.

The solution of the case for diagnosis in our last issue was found at the operation which was undertaken because of the increasing severity of her symptoms and because of the increased resemblance to a case of intestinal obstruction. Fat necrosis was observed and blood-stained fluid was universally present, and a large hæmorrhagic condition of the pancreas was found. The diagnosis was therefore "acute hæmorrhagic pancreatitis." We hope to publish Dr. Fawcett's Clinical Lecture at an early d te.

The institution of a Cup for the second XI.'s of the cricketing hospitals is the inevitable result of modern competition in games. It has done no harm in our Soccer world, and has evoked great keenness, and we hope it will be well supported. The abundant energy of our cricketers has resulted in three XI.'s frequently being put into the field, and we hope that the Cup will find a resting place for the first year in the Guy's Smoking Room.

We print elsewhere a list of the fixtures and the result of the draw for the Hospital Cup. With Fate's usual perversity one hospital is presented with as smooth a path to the Final Tie as possible, while the remaining hospitals are all in one division. It is to be hoped the fiasco of last year's Cup Tie will be avenged this year under the captaincy of H. M. Langdale.

Pass List.

University of Cambridge, April, 1903.

EXAMINATION FOR THE DIPLOMA IN PUBLIC HEALTH.

G. E. Richmond.

University of Durham, April, 1903.

EXAMINATION FOR THE DEGREE OF BACHELOR IN MEDICINE.

C. M. Anthony.

Second Conjoint Examination, April, 1903.

G. Cockcroft, C. F. Fothergill, H. G. Gibson, T. R. Harvey, T. B. Layton, P. F. McEvedy, J. H. Mayston, G. H. Morris, H. A. Pallant, E. E. Rendle, G. G. Timpson, H. E. H. Tracey, A. Zorab.

First Conjoint Examination, April, 1903.

Part I.

Chemistry.—F. J. Gillett, E. P. L. Hughes, C. F. L. Leipoldt, C. E. Price, J. N. Watson, J. A. Von W. Wiehe.

Part II.

Practical Pharmacy.—H. W. Bethell, M. Maher, B. B. Metcalfe, C. S. Morris, E. H. Paterson.

Part III.

Elementary Biology.—H. N. Eccles, A. Alan Forty, F. J. Gillett, D. W. Jones, E. N. Plummer. A. H. V. St. John, W. H. Watson.

Licence in Dental Surgery, April, 1903.

PRELIMINARY SCIENCE EXAMINATION.

R. P. Fenn. H. G. Pearce.

Annotations.

"Ne quid nimis."

THE LONDON COUNTY COUNCIL AND THE APPOINTMENT OF OFFICIAL PATHOLOGISTS.

We reprint (by the kindness of the *Lancet*) the reply of the Hospital Medical Committee to the County Council enquiry about competent Pathologists. Before the institution of the present unsatisfactory régime the special pathologist was paid *five* guineas and he did not find it remunerative. The reply is so absolutely straight and direct that it should help the settlement of a very tiresome bother.

From the London County Council to the Secretary of Guy's Hospital.

County Hall, Spring-gardens, S.W.,
16th March, 1903.

SIR,—The Council considers it desirable that post-mortem examinations in inquest cases of a special nature should be intrusted to specially skilled pathologists.

I have been directed to bring the matter to the notice of the authorities of Guy's Hospital and to express the hope that they will kindly assist the Council in the matter of suggesting, with a view to a selection being made, the names of well-qualified pathologists with experience of a medico-legal nature who are attached to Guy's Hospital, and who would be prepared, if called upon by any of the London coroners, to make post-mortem examinations and to give evidence in special inquest cases. The inclusive fee would be £2 2s.

May I ask you to kindly place this letter before the authorities of the hospital at the earliest opportunity.

I am, Sir, your obedient servant,
(Signed) G. L. GOMME, Clerk of the Council.

From the Medical Committee of Guy's Hospital to the London County Council.

April 3rd, 1903.

SIR,—With regard to your letter, dated 16th March 1903, which was referred by the superintendent of Guy's Hospital to the medical and surgical staff, I have been requested to make the following communications:—

1. That the medical and surgical staff of Guy's Hospital approve of the suggestion of the County Council to provide specially skilled pathologists to undertake post-mortem examinations in inquest cases of a special nature.

2. That they are, however, strongly impressed by the fact that in many cases a safe conclusion as to the cause of death cannot be arrived at from the conditions found post-mortem alone, and that medical evidence as to the preceding illness is then absolutely essential to a right judgment and should be obtained whenever possible.

3. That it is also obvious that in cases of sudden death or persons found dead the attendance at the post-mortem examination, and the evidence at the inquest of the medical man who first sees the corpse may be desirable.

4. That while very willing to afford assistance in the furtherance of the objects of the Council, they are of opinion that it is impossible to secure the services of pathologists of the required standard for the fee of two guineas.

I am, Sir, yours truly,
J. H. BRYANT,
Hon. Sec. to the Medical Committee
of Guy's Hospital.

G. L. GOMME, Esq., the Clerk of the County Council.

The Medical Committee of Guy's Hospital has taken, in our opinion, exactly the right line. No one disputes the great value of skilled pathology in post-mortem examinations, while the necessity in special cases of coroners being able to obtain the best expert assistance is equally evident. But no amount of evidence obtained from post-mortem investigation of a corpse will ever make it possible to dispense with the evidence of the medical man who has seen the patient when alive, and can speak as to the facts of the last illness and all its attendant circumstances. This is the error into which Mr. Troutbeck has been betrayed. The objection taken by the medical committee of Guy's Hospital to the meagre fee is one that will be indorsed by all the other hospitals. Expert advice in special cases ought not to be invited upon such terms. The services of pathologists of the required standard cannot be secured for the fee of two guineas.—*The Lancet.*

From the Gazette's Special Pathologist.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

NOTICE.

E. H. G., LAMPETER (marked Mrs. Green).—Reaction, faintly acid; sp. gr., 1006; albumen a trace only; sugar absent; blood absent. Microscopical examination of the centrifugalised deposit. The deposit was composed of squamous cells from the vagina and a small number of leucocytes. Neither casts nor crystals were seen, there was no pus or blood, and tubercle bacilli were not found.

PATHOLOGIST.

Papers by Guy's Men.

Notification and Diagnosis of Infectious Disease. By Herbert Manley, M.D., D.P.H.—*The Birmingham Medical Review*, for April.

Some Observations on the Protective Bodies and on their Relation to Bacterial Virulence. By E. W. Ainley Walker, M.A., M.D.—*Centralblatt. f. Bakteriol. Parasitenk.*, u.s.w., 1903, vol. 33, No. 4.

A Case of Syphilis in which the Stages were rapidly produced.

A private of Marines, aged 20 years, was placed on the sick list on 25th January, 1892, suffering from a small soft sore in the sulcus of the frænum præputii, the result of a connection on 17th January in Valparaiso. There was neither glandular enlargement nor induration of the sore.

Strong nitric acid was applied and iodoform used afterwards. The sore was healed in six days, and the man returned to duty.

On 17th February he presented himself for treatment of an eruption which had appeared the previous day, and which, on examination, presented all the characters of an early specific roseolous rash. There was no induration about the site of the sore. The cervical glands were shotty and the throat was affected. There was a slight rise of temperature every evening to just above 100° F. Mercurial treatment was started at once, and at the end of a week the throat was well and the rash had dwindled to a slight staining. He returned to duty, but continued to take mercury.

On 15th April he was laid up with synovitis of the left knee, which had come on suddenly and without any traumatic reason. He was found to be thickly covered with a papular eruption. He was sent into hospital, and remained there until 10th May, when he was discharged well. He continued to take mercury.

On 20th May he had a severe attack of iritis in the left eye, circumciliary congestion, cloudy cornea, iris muddy and sluggish, intense photophobia and lachrymation. Belladonna was applied locally, and the mercury changed from pil. hydrarg. to biniodide. He remained on the list for twenty-three days, and was discharged with no adhesions of the iris, nor were any splashes present on the surface of the lens.

On 24th June he had a recurrence of the iritis, and was under treatment until 10th July. He continued mercurial treatment in a mild form on returning to duty.

On 30th September he again came on the list having a small gumma at the upper end of the sternum just below the notch, in the middle line. Biniodide was again given. The gumma suppurated and was opened. A few days later, as healing was not satisfactory, the sinus was explored, and dead bone felt. The patient was anæsthetised, and the necrosis was found to be limited to a superficial flake which was thoroughly scraped away, after which healing quickly took place and he returned to duty.

Up to June, 1893, no fresh developments occurred.

Assistant Demonstrators of Histology.

Brookhouse, H. O. Layton, T. B.
Cockcroft, G. Reynolds, R. J.

University of London.

PRESENTATION DAY.

Presentation for Degrees and Honours, 1903, at the Royal Albert Hall, on Wednesday, 24th June, at 9 p.m., on which occasion Honorary Degrees will be conferred on Their Royal Highnesses the Prince and Princess of Wales, and on Lord Kelvin and Lord Lister.

Graduates of the University desiring to be present are requested to make application *before the 9th May* to the Principal, University of London, South Kensington, S.W., stating their name and degree.

Should the number of applicants exceed the number of seats available, a ballot will be taken and tickets will be sent only to those who are successful in the ballot. Graduates will be expected to appear in academic costume.

We understand from the Dean that the members of the University are anxious that not only graduates, but undergraduates also be present, in order that the Schools of the University shall be thoroughly represented. We hear that very good places indeed have been reserved for a large number of men, and so hope that those of our own school will take advantage of the arrangements to be made and will apply for tickets.

It is the first occasion on which Honorary Degrees have been granted by the London University and inasmuch as our President and the Princess of Wales are two of the recipients, it behoves us still more to be present on the occasion. Evening dress and academic costume for undergraduates as well as graduates, will be *the* correct thing for the occasion, though not compulsory.

As regards the notice of application by graduates, the last day for application is put down as May 16th, but as many of our graduates have probably not seen notices about it before, they should, in the event of desiring to be present, write at once to the Principal for tickets.

Prizes and Scholarships.

Golding-Bird Gold Medal and Scholarship in Bacteriology.—Mr. N. Ivens Spriggs.

Michael Harris Prize in Anatomy.—Messrs. H. O. Brookhouse and G. Cockcroft (equal), £5 each; Mr. T. B. Layton, Certificate.

Wooldridge Memorial Prize in Physiology.—Mr. H. O. Brookhouse, £10; Mr. G. Cockcroft, Certificate; Mr. T. B. Layton, Certificate.

Junior Proficiency Prizes.—Mr. H. O. Brookhouse, 1st Prize, £20; Mr. G. Cockcroft, 2nd Prize, £15; Mr. T. B. Layton, 3rd Prize, £10.

Dental Mechanics Scholarship.—Mr. H. Snell, £20.

Change of Address.

On behalf of, and under the supervision of, Dr. R. J. Pritchard, who was partially crippled by a carriage accident while in practice at Fittleworth, a private nursing home has been opened by his friends at Risca, Reigate. References are given by several members of the Guy's Staff, and all information may be obtained on application.

E. I. Claxton, M.B., B.C., B.A., has settled in practice at 125, Great Mersey Street, Liverpool.

O. Marriott, Esq., has settled in practice in partnership in Hong Kong. He is, we believe, the only Guy's man in this Far Eastern Settlement. Address, Bank Buildings, Hong Kong, China. A.B.C. Code. Telegraphic address, Kremlu.

E. W. H. Shenton, Esq., M.R.C.S., has removed to 67A, Harley Street, W.

Lawrie H. McGavin, Esq., F.R.C.S., has removed to 6, Mansfield Street, Cavendish Square, W.

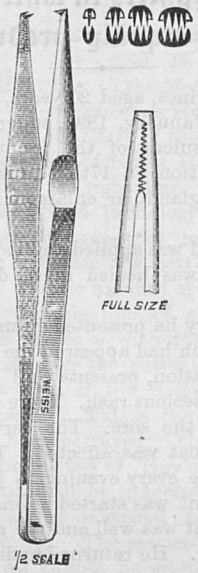
Novelties.

These instruments can hardly claim to be novelties as they have been in use for some time, but as they seem to have met with very general adoption they may be printed here—

TISSUE FORCEPS.

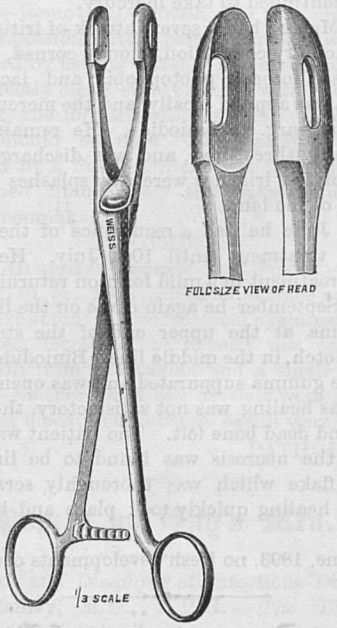
The Tissue Forceps are much used for flaps, for buttoning towels to the raw surfaces so as to exclude any possibility of ligatures touching any skin, and for any purpose in which tissues are required to be pulled. The bite right through in practice has never yet damaged the flaps at all. They are an adaptation of the bull-dog forceps that were formerly used for arteries, and are most useful to any operator.

LANE'S DISSECTING FORCEPS.



Lane's Dissecting Forceps, made in the longest size, are provided at the biting point with interlocking sharp teeth. They are of great service especially the three toothed and the five toothed pairs.

BONE-CUTTING FORCEPS.



The Bone Cutting Forceps are also much used for cutting bone edges, for carious bone, and for tuberculous granulations and sinuses. They are strong and sharp.

The above instruments were devised by Mr. Arbuthnot Lane and are commonly known by his name.

Obituary.

Francis Wheler Sime.
I.M.S.

The late Francis Wheler Sime, I.M.S., was born in India twenty-six years ago. His father, Dr. John Sime, C.I.E., who is a Scotsman, and native of Perthshire, held at the time of his retirement from the service of the Indian Government about two years ago, the appointment of Director of Public Instruction in the Punjaub. His mother is an English lady, daughter of the late General Henry Palmer of the Indian army.

At a very early age his parents brought him to England and boarded their son at Bruce Castle, a private educational establishment near to London; thence he was taken to a similar school in Clifton, near Bristol, and afterwards coming to Scotland was placed as a border in Stanley House School, at Bridge of Allan, where during the course of his studies he made many friends, and to the delight of his schoolmates and masters alike, especially distinguished himself in athletics, gaining the Scottish championships in both the 100 yds. and 220 yds. sprints.

After matriculating he then enrolled himself as a student at Guy's, and passing out from there in due course, at once prepared himself for entering the I.M.S. Successful again in this final examination he was only about six months ago ordered to proceed to Lahore, in the Punjaub, and thence under further orders he accompanied the troops into Somaliland in the expedition against the Mullah, where unfortunately he has fallen at the outset of a career full of much promise.

His record at Guy's was thoroughly sound and good. He took the Conjoint and Durham degrees in the shortest possible time. He was member of a redoubtable firm of Clinicals and House-Surgeon to Mr. Arbuthnot Lane, under whose supervision he performed with great success a very large number of the major operations in surgery, reaching for his time, we believe, the high-water mark in that respect. He was then Charity to Dr. Galabin, and proceeded shortly afterwards to the I.M.S.

His athletic and social record was a successful one. He won the Scottish Open Championship at the 100 and 220 sprints, played with S. Anderson for Northumberland in the County Championships, and won the Inter-Hospital Cups for the 100 and 220. He was a member of the famous 1898 winning Cup team. He was well over six feet and of great strength, and a man of fine physique, and of striking appearance. He was universally popular and is much lamented. Of him we may say, as Beaconsfield once lamented, "Home is dead and I destined him to high command."

He was typical of the best we turn out, and of him as of his colleagues and friends, Patrick Manson, and M. D. Wood, whose loss we have so recently deplored, we can only say the world is poorer for their loss, and their friends are deeply grieving.

Reviews.

The price of books submitted for review should in every case be stated.

A System of Clinical Medicine. Thomas D. Savill, M.D. Vol. I.: Local Diseases and Microbic Disorders. (J. & A. Churchill. Price 12s. 6d. net. 670 pages and illustrations).

Systems of Medicine are on the increase, and naturally involve a great deal of repetition. One system differs from another by but a small increase in teaching, and any system which is smaller than the large system naturally labours under the stigma of having omitted material facts.

The above volume is a clinical account of medicine written in a pleasant readable form and inclined to dogma and definite statement. A book on medicine is a treatise in which *facts* are clearly stated, but experience shows it is often dangerous to state definitely what inferences those facts can bear. That is a great fault in the book. Throughout, a tendency to decided tone and dogmatic statement, has overweighed the less comforting fact that diagnostic facts are very scarce things in practical medicine.

There are several errors, or rather half truths, and also many omissions. But with all these criticisms, and criticism is invited by a "system" of medicine, there is offered a readable, on the whole very accurate, up-to-date book, some parts of which are very good and which has the advantage of not considering gynæcology as a thing apart from medicine, and there are many articles that are very good.

The Mycology of the Mouth. By Kenneth W. Goadby. (Longmans, Green & Co.) 240 pages, 82 illustrations Price 6s. net.

This is an extremely well conceived work. It stands practically alone as a scientific attempt to deal with the extremely complicated conditions of oral bacteriology and sepsis. The attempt has been most successful, and the work all but holds the field at present. There is a vast field for research in the organisms present in the different parts of the body, and with the exception of the intestines the mouth offers the widest scope.

In view of the fact that progress in dental surgery, as in medicine, will probably lie along the discoveries in bacteriology, it is quite important for all men to get a clear idea about the present state of our knowledge, and if possible to supplement the book teaching by a thoroughly practical course before entering practice, if he does not wish to be out of date in six years time, hearing of advances and but vaguely comprehending them. It is accurate, instructive, and quite an adjunct to any dental library, and bears evidence of laborious and careful work.

In Lighter Vein.

TERRIBLE FIRE IN THE BOROUGH.

APPALLING DETAILS.

REVOLTING INCIDENTS.

DR. FR-YB-RG-R SPEAKS OUT.

Considerable excitement was aroused the other night by the curious behaviour of a chimney pot in the surgical buildings. In violation of all the laws of chemistry and physics, the said chimney pot caught fire and burned merrily for a short time. Fortunately the chimney pot was on the top of the roof. Had it been in one of the wards, or in the telephonic exchange, when it caught fire, the results might have been appalling in their severity and blood curdling in their horror. As it was they weren't. Dr. Fremantle was the brave man who discovered it first. He had just gone out to post a letter to the *Times* and was returning when the chimney pot caught his eye. No damage was done. With admirable presence of mind he at once awoke his colleague of the ear-hole department and discussed the advisability of incorporating the incident in the new edition of his book. As the old edition is not yet exhausted (Advt. Ed.) it was decided that some other steps should be taken. The Charities being persons of considerable common sense were therefore invited to join the board and the matter was carefully discussed. As no definite conclusion was reached the committee adjourned to the surgical buildings to read the placards about procedure in case of fire. Some doubt was expressed as to the whereabouts of Dr. Steele who seemed to be of considerable importance on these occasions. Attempts were made to get into communication with W. Chapman who also appears to be in the coal trade. While these steps were being taken, Dr. Fremantle beguiled the time by reading short extracts from his book. Much amusement was caused by the appearance of the Deputy-assistant-superintendent in his new fireman's uniform. He at once realized the gravity of the situation and commenced to break all the windows with his little axe. This, he explained, was always done by real firemen. At this stage it was noticed that the Charities had got on the roof with axis traction forceps under a mistaken idea of the nature of the case. Fireman Smith attempted to follow them with his little axe, but was hauled back by a house-physician, who thought a cold pack was indicated. Fireman Smith then turned up the job and went to bed. The plumber was next called into consultation. He said it was not a plumber's job but a chimney sweep's, and suggested calling the latter officer. Just to show he was not afraid, however, he climbed on to the roof and was promptly "verted" by the indignant Charities. Mr. Barnes, communicated with by telephone, said that the fire had not yet entered his department. He requested to be called should the telephones catch fire or blow up and then switched off. By this time quite a little crowd of loafers had collected, and Dr. Fremantle seized the opportunity to deliver a short lecture on the inefficiency of the War Office. Mr. Brydone, arriving from headquarters hurriedly on his motor fire-engine, yclept "Gumma," at once explained what ought to be done. He apologised for his late appearance, but said it was a heavy job shoving his motor along the Boro'. He could have come much quicker if he'd walked. He suggested that the whole thing was hysteria on the part of the chimney-pot, and offered to lay long odds against anything with anyone. At this stage some disturbance was created by Mr. Wrench attempting to do a blood count on Dr. Fremantle. He was removed by the police. Mr. Tommy Hicks now arrived in a great state of indignation. He said the fire ought to be put out, and he would do it himself if he were tall enough. He tried to reach it by standing on his hat, but it was no good. He then went back and brought out Dr. French (of St. Thomas' and Newcomen Streets), who at once smothered the conflagration with his hat.

"And ever ensconced in calm repose
The 'Super.' slept uncalled."

The Students' Club.

The Annual General Meeting of the Student's Club was held in the Anatomical Theatre on Tuesday, March 24th, at 4.15 p.m.

Dr. Pye-Smith was in the chair. About 40 members were present. The minutes of the previous meeting having been read and confirmed, the Chairman requested the meeting to select three members to serve on the Committee.

Six members having been proposed and seconded, a ballot was taken and Messrs. O'Brien, E. Morgan and H. D. Wyatt, having received the greater number of votes, were duly elected. Mr. Collins Lewis drew the attention of the Committee to certain inconveniences experienced by members during the sweeping of the Smoking Room in the afternoon. The Secretary pointed out that it was necessary for the Smoking Room to be swept out after the luncheon time, and that it was done when most men were away in the wards or elsewhere. A discussion then arose on the constitution of the Students' Club Committee. Mr. Brydone regretted the severance of the Committee into members representing the residents in the College and those representing the non-resident members, and advocated a general meeting being held, at which six members should be elected. Mr. Robson dissented from Mr. Brydone's proposal on the ground that the members residing in the College ought not to risk being unrepresented on the Committee since their relation to the Club was more intimate than that of the non-residents.

Messrs. Milsom, Mann, Collins, Lewis and O'Brien also joined in the discussion.

On an appeal being made by the Chairman, the matter was allowed to drop. The Secretary having given an assurance that before the next Annual General Meeting he would prepare a list of gentlemen willing to serve on the Committee, and publish them in the Gazette and elsewhere, so as to ensure greater publicity.

Mr. Cooper then proposed a vote of thanks to the Chairman, and the proceedings terminated.

Mr. A. M. Webber and Mr. F. W. M. Palmer were elected by a meeting of the Residents as their representatives on the Club Committee.

Appointments.

MILITARY.

Lieutenant-Colonel W. A. May, C.B., R.A.M.C., is promoted to be Colonel. During the recent war in South Africa he was Principal Medical Officer of a Division, was mentioned in dispatches, and made a Companion of the Order of the Bath. Colonel May, who is now Principal Medical Officer, Natal, has, we understand, been appointed Principal Medical Officer in Egypt.—*British Medical Journal.*

Sport.

Cricket.

LIST OF MATCHES.—First Eleven.

Date.	Time.	Against.	Ground.
May 9...	11 0	Beckenham	Beckenham.
„ 13...	11 0	London County C.C.	Honor Oak Park.
„ 16...	11 0	Wanderers	Honor Oak Park.
„ 18...	11 0	M.C.C.	Honor Oak Park.
„ 20...	11 0	Blue Mantles	Tunbridge Wells.
„ 23...	11 0	R.I.E.C.	Cooper's Hill.
„ 27...	11 0	Surrey Club & Grnd.	Honor Oak Park.
„ 30...	11 0	Reigate	Reigate.
June 3...	11 0	Mr. C. Bonsor's XI	Away.
„ 6...	11 0	Hornsey	Honor Oak Park.
„ 10...	11 0	Hampstead	Hampstead.
„ 13...	11 0	Wellingboro' Masters	Wellingborough.
„ 17...	11 0	London County C.C.	Crystal Palace.
„ 20...	11 0	Past	Honor Oak Park.
„ 23...	11 0	Hornsey	Hornsey.
„ 27...	11 0	Old Cranleighans	Honor Oak Park.
July 1...	11 0	Gravesend	Gravesend.
„ 4...	11 0	Heath Asylum C.C.	Bexley.
„ 7 / „ 8	11 0	Mr. Laycock's XI.	Bawtry Notts.
„ 11...	2 30	Addiscombe	Honor Oak Park.
„ 15...	11 0	Eltham	Eltham.
„ 18...	11 0	Streatham	

Second Eleven.

May 6...	2 0	Merc. Taylors Sch. 'A'	Honor Oak Park.
„ 9...	2 0	Old Charlton	Honor Oak Park.
„ 13...	2 0	Manor House School	Away.
„ 16...	2 0	London Hospital 'A'.	Hale End.
„ 20...	2 0	London Hospital 'A'.	Honor Oak Park.
„ 23...	2 0	Old Olavians	Honor Oak Park.
„ 27...	2 0	St. Bart's Hospital	Winchmore Hill.
„ 30...	2 0	R.I.E.C. 'A'	Honor Oak Park.
June 3...	2 0	St. Thomas's Hosp.	Honor Oak Park.
„ 6...	2 0	Merc. Taylors Sch. 'A'	Away.
„ 10...	2 0	City of London Sch.	Honor Oak Park.
„ 13...	2 0	Old Charlton	Charlton Park.
„ 17...	2 30	Norbury Park 'A'	Norbury.
„ 20...	2 30	Blackheath 'A'	Blackheath.
„ 24...	2 30	St. Thomas's Hosp.	Chiswick.
„ 26...	11 30	Thespids	Honor Oak Park.
July 1...	11 30	Kingston Hill	Honor Oak Park.
„ 4...	2 0	St. Bart's Hospital	Winchmore Hill.
„ 8...	11 30	Thespids	Honor Oak Park.
„ 11...	2 0	Old Olavians	Away.
„ 15...	2 0	Manor House School	Honor Oak Park.

Third Eleven.

May 4...	2 0	New Eltham	Honor Oak Park.
„ 16...	2 0	Sevenoaks School	Sevenoaks.
„ 23...	2 0	Boro' Road Col. "A"	Isleworth.
„ 30...	2 0	Camberwell House	Away.

June 6...	2	0	Quernmore Sch. "A" Bromley.
„ 13...	2	0	Boro' Road Col. "A" Honor Oak Park.
„ 20...	2	0	Home and Colonial Away.
„ 27...	2	0	Camberwell House... Away.
July 4...	2	0	Hos.-Scho. .....Honor Oak Park.
„ 11...	2	0	New Eltham .....Eltham.
„ 18...	2	0	Quernmore Sch. "A" Bromley.

SENIOR CRICKET CUP.

A St. Thomas's, B Middlesex } E v. Guy's
C St. Bart.'s, D London } F v. University
} Final.
Rest } King's, Mary's
Byes } Westminster, Charing Cross

First Round by May 31st. Third Round by June 28th.
Second „ „ June 14th. Final „ „ July 12th.

JUNIOR CRICKET CUP.

A St. Thomas's, B Middlesex } Guy's - Bye
D St. Bart.'s, E London } F Mary's - Bye
} Final.

First Round on June 1st.

United Hospitals' Cricket Club.

At a General Meeting of the above Club held on April 3rd, 1903, it was resolved that a Cup, kindly presented by Dr. Gayton of the London Hospital, should be termed the Junior Inter-Hospital Cricket Challenge Cup, and should be competed for annually by the second teams of the various hospitals.

The following are the conditions ruling the competition:—Each hospital provides its own umpire, not necessarily a professional, save in the final, when the umpires must be neutral. The matches are half-day, beginning at 2 p.m., save in the final, which is a whole-day match, beginning at 10.30 a.m. The United Hospitals' Cricket Club limits itself to the expense of providing balls, and engraving the name of the winners on the cup annually. All other conditions attached to the competition are analogous to those governing the Junior Association Cup, *i.e.*, as regards ground, eligibility, etc.

F. MORRES,
Hon. Sec. G.H.C.C. and U.H.C.C.

Guy's Hospital Athletic Club.

At the Annual General Meeting of the above club held on March 26th, 1903, in the Anatomical Theatre, the following officers were elected:—Hon. Secs: J. E. Hodson, P. C. Litchfield. Committee: To represent 1st year, T. E. A. Carr, B. W. Pinching; 2nd year, E. L. Pilbeam, J. L. Rankine; 3rd year, A. W. Berry, A. Zorab; 4th year, E. Morgan, R. W. Allen; 5th year, E. L. Norton, A. M. Roome; any year, E. Wragg.

Guy's Hospital Lawn Tennis Club.

Date.		Against.	Ground.
May	2	Trial Match ...	Home.
	9	Sidcup	Home.
	16	Redhill "A" ...	Redhill.
	20	Blackheath "A" ...	Blackheath.
	23	Wanstead	Home.
	27	Harold	Home.
	30	Kent	Blackheath.
June	3	Boundaries	Wandsworth Com.
	6	Surbiton "A" ...	Home.
	13	Blackheath "A" ...	Home.
	17	Connaught	Chingford.
	20	"The Past" ...	Home.
	24	Redhill "A" ...	Home.
	27	Brixton Wanderers...	East Dulwich.
July	1	The Staff	Home.
	4	Brixton Wanderers...	Home.
	8	Gravesend	Gravesend.
	11	Surbiton "A" ...	Surbiton.
	15	Harold	Gipsy Hill.
	18	Boundaries ...	Home.
	25	Kent	Home.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Birth.

GROVE.—On April 26th, at St. Ives, Huntingdonshire, the wife of W. Reginald Grove, M.B., of a daughter.

Marriages.

CRAIG—BROCK.—On April 16th, at the Parish Church of St. Peter-Port, Guernsey, Maurice Craig, M.D. Cantab., to Edith de Saumarez, only child of Kentish Brock.

MUNRO—KAY.—On April 22nd, at St. Mary's Church, Hartlepool, by the Rev. Father Wickwar, Donald John Munro, M.B., B.S. Lond., of 56, Acre Lane, Brixton, S.W., to Louise Mary Edith, eldest daughter of the late T. J. Kay, Esq., Solicitor, and Mrs. Kay, of Rockside, Hartlepool.

THOMAS—COOPER.—On May 6th, at St. Michael's and All Angels, Bournemouth, by the Rev. A. W. Stote, Lieutenant and Quarter-Master Gwynne Cecil Thomas, West African Frontier Force, to Marian Wreford, eldest daughter of James Cooper, Esq., of Bournemouth.

Ed.—J. M. B.

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Calendar of Coming Events.

May, 1903.

Sat. 23.—Messrs. Symonds and Stewart's take-in; Drs., E. C. Myott and A. M. Benett; Cl., N. I. Spriggs.
G.H.C.C., I., v. R.I.E.C., 11 a.m., Cooper's Hill.
II., v. Old Olavians, 2 p.m., home.
III., v. Boro' Road College "A," 2 p.m., Isleworth.
G.H.L.T.C., I. v. Wanstead, home.

Mon. 25.—1.15 p.m., Clinical lecture by Dr. Perry.
1st and 2nd Year's Dental Students, Exam. for Prizes, 9 a.m.
2nd Year's Dental Students, Clinical Exam. for Prize, 2 p.m.

Wed. 27.—1.30 p.m., Clinical lecture by Dr. Shaw.
G.H.C.C., I., v. Surrey Club and Ground, 11 a.m., home.
II., v. St. Bart.'s, 2 p.m., Winchmore Hill.
G.H.L.T.C., I., v. Harold, home.

Thur. 28.—Messrs. Lucas and Lane's take-in; Drs., A. V. Maybury and C. P. Harvey; Cl., R. G. Anderson.
1st Year's Dental Students, Clinical Exam. for Prize, 2 p.m.

Fri. 29.—1.15 p.m., Clinical lecture by Mr. Dunn.

Sat. 30.—G.H.C.C., I., v. Reigate, 11 a.m., Reigate.
II., v. R.I.E.C. "A," 2 p.m., home.
III., v. Camberwell House, 2 p.m., away.
G.H.L.T.C., I., v. Kent, Blackheath.
1st and 2nd Year's Dental Students, Laboratory Exam. for Prizes, 9 a.m.

June.

Mon. 1.—Whitsun Monday. Medical School Office closed.
Last day for applying to Registrar for Form of Entry for Pri. Sci. M.B. Lond. Exam.

Tues. 2.—July Appointment List opened.
Mr. Rowell's Demonstration on Anæsthetics, 12 noon.

Wed. 3.—1.30 p.m., Clinical lecture by Dr. Shaw.
G.H.C.C., I., v. Mr. Cosmo Bonsor's XI., away.
II., v. St. Thomas', 2 p.m., home.
G.H.L.T.C., I., v. Boundaries, Wandsworth Common.

Fri. 5.—1.15 p.m., Clinical lecture by Mr. Dunn.

Sat. 6.—G.H.C.C., I., v. Hornsey, 11 a.m., home.
II., v. Merchant Taylors' School "A," 2 p.m., away.
III., v. Quernmore School "A," 2 p.m., Bromley.
G.H.L.T.C., I., v. Surbiton "A," home.

Guy's Hospital Gazette,

MAY 23, 1903.

The Operative Treatment of Gastric Carcinoma.

CLINICAL LECTURE BY MR. CHARTERS SYMONDS
March 25th, 1903.

GENTLEMEN,—I propose to-day to discuss some of the main points which you have to consider in advising an operation upon the stomach for the relief of the symptoms produced by carcinoma. The treatment of cancer of the stomach may be divided like most other cases of carcinoma, into palliative measures and curative measures. The palliative treatment consists in relieving the obstruction to the stomach by diverting the course of the food, the curative in excision of the growth. The palliative treatment would mean, as I think you already understand, making a new opening from the portion of the stomach above the obstruction and the growth, into the intestine below. Curative operation, *i.e.*, excision of the growth, is only possible, when the growth is strictly localised, or when it is limited to the pyloric end; secondly, when there is no infection, or a very limited infection of the lymphatic glands; thirdly, when it is not adherent to the posterior wall. A growth which permits of excision, therefore, should be freely movable, not adherent to the posterior wall; there should be no enlargement of the lymphatic glands, especially about the head of the pancreas. The

few lymphatic glands in the great omentum, and in the gastro-hepatic omentum, are of no great moment compared with those about the head of the pancreas. In about forty cases explored or operated upon, in only three was resection possible, and it was performed; but in no single instance was removal of the cancer of the glands complete. It seemed to be complete in one case with regard to the stomach, and that patient I will show you presently; but it was not complete as regards the lymphatic glands about the head of the pancreas, a very difficult place to deal with.

The next point to consider is what cases are suitable for operative treatment of a palliative kind. A typical instance is that of a woman, æt. 51, who was admitted after some months of dyspepsia. She vomited a large quantity of material in the usual way about once a day. These excellent drawings, made by one of our late students, Mr. Murray Thomas, show a dilated stomach below the level of the umbilicus and to the right of it. And on the right of the umbilicus there was a large hard mass. After the stomach had been washed out the tumour lay beneath and above the umbilicus, and you can see the reduction in capacity. In this particular patient we have three things to notice; first, the enormous dilatation of the stomach; secondly, the presence of a mass which moves with the varying distension of the stomach; and thirdly, very marked peristaltic action. The patient was operated upon by gastro-enterostomy, and lived about a year in comparative comfort.

Another typical example was that of a man of the same age, who had reached the lowest possible ebb of starvation. He was sick only once a day, but then he brought up more than he had taken. He had, like the last patient, a typical lump, enormous dilatation, and marked peristaltic action. He was operated upon and lived over a year. In the first six months he gained two stone in weight and was able to go about as usual. Then occurred the usual course of events, recurrence in the peritoneum and death. There are in the list a good many cases of this type, but I have summarised the points which are common to all of them. There is gastric dilatation, with peristalsis, and vomiting at long intervals; that is to say, these patients suffer from obstruction; they do not suffer from the cachexia of malignant disease but from obstruction, and for that reason they are the most suitable cases for operation, whether palliative or the curative, *i.e.*, excision. I have gone so far as to say in the syllabus that they all do well, and that they will stand any operation of this type that may be suggested or planned, even if they are very emaciated. These patients can be fed as soon as they are over the shock of the operation; you can give them a pint of fluid within the first twelve hours, or more than that if necessary, without any risk and generally without vomiting. I therefore always look upon this type of case as one eminently suitable for operation. That is one type, but unfortunately, in my experience, it does not form the larger class.

The second type of case which has come under my notice is that of Mr. Z., who left Australia suffering from indigestion and dyspepsia, and was not very well generally. It was thought by his medical adviser there that a voyage would do him good. When he arrived here the indigestion had rapidly increased, and he then began to vomit. The characteristic points were that his vomiting was frequent, and only small quantities came away, he also loathed his food, a not infrequent symptom in this class of case. In a week the loss of weight was very marked, and vomiting and repulsion to food increased. We found an irregular central mass which moved slightly on respiration. There was no dilatation of the stomach, no peristaltic action, and the vomiting occurred soon after he took food. That was the general picture, and it is an important point to bear in mind in giving a prognosis in these cases. This lump was not very definite, but when the intestines were emptied we could distinctly feel a mass moving on respiration, and apparently covered over somewhat by the liver. It was, therefore, felt that we ought to do something for him if he were to return home. With those symptoms before us, that is to say, with rapid emaciation, no dilatation, and no peristalsis, but with a central irregular mass that moved only slightly—an important point—one could

only say that the disease was probably primarily in the body of the stomach, and that it was probably creeping towards the pylorus, and that his symptoms were due more to extensive ulceration than to obstruction. It also seemed that the other factor reducing his health was a spreading of the malignant disease and consequent cachexia. However, it seemed a fair case on which to make some attempt to afford relief by operation. I operated upon him and found the stomach extensively diseased, so that a good third of the viscus was involved. However, one was able to complete the operation of gastro-enterostomy by the posterior method, and he improved in health rapidly. He was able to take his food, gained slightly in weight, and travelled back to Australia. He arrived safely, and was able to attend to his business for a time, living about nine months altogether after operation. Distinct relief followed this palliative measure, though one could not promise him as long a life as we could in the first type. There are several cases of this type, cases in which you can feel a lump, which moves only slightly, and in which the patient is pretty ill. I think the anxious question to decide is whether you can do much good in these cases. This particular case I think justified the step which was taken. There are several others. One was, singularly enough, another Australian. He came over to the Coronation with the same idea, that the voyage would do him good. But he rapidly went downhill and I found the same conditions. He has returned to Melbourne, and I heard not long ago from his medical man that he was beginning to see signs of failure, though he had picked up very much in the interval after the operation. I remember another man, a German, who was getting into the same state; very sick, no dilatation, but a lump was to be felt. There was no peristalsis, and the operation was attended with extreme difficulty because the stomach was fixed. However, he did well, and lived for some little time, not having been sick since the operation.

You will see from what I have pointed out to you that there is an immense contrast between this type of case and the first type; so that in giving your opinion from the clinical aspect of the case—and it is that I want you to pay special attention to—you will be able to say that this type of case can be relieved, but the operation may be extremely difficult, and it may be better to abandon the operation when the abdomen has been opened because of the fixation of the stomach, and the general infection.

There is a third type, and it is the most difficult of the three. We have a very good instance of that in a man æt. 65; he was a barber, a very clever man, and evidently of remarkable vigour. It was his remarkable energy which led me to operate upon him, though I do not think I should have done so in a similar case in a different type of man. He had had symptoms of stomach trouble for a very long period; and when I look at the couple of pages of notes which I have for this man it seemed impossible to think that he could have had cancer of the stomach. At one time he was well, and at another time he was vomiting. Then the vomiting disappeared and he got better in health. The point about it is this: that there is a long history of stomach trouble, and I use the words stomach "trouble" in a general way, because these are curious cases, in that they have dyspepsia and indigestion, and you do not find the ordinary signs of dilatation, or obstruction, or peristalsis, or an abdominal mass. As the case advances, these are the things which strike me as being more or less diagnostic: first, that there is pain immediately on taking food; the next point is that these patients are unable to take more than quite a small quantity. I have given these patients small quantities of water to swallow; a teacupful is as much as such a patient can take sometimes.

We had a case a little while ago in Mary ward, with malignant obstruction of the lower end of the œsophagus. I put a tube through into the stomach, but we could never get down more than one ounce, and concluded that the tube was not in the stomach. I performed a gastrostomy for her relief, and found scarcely a palm's breadth of stomach free from growth. I was able to complete the operation, and we fed her through the wound. She lived some days, but we could never get more than one ounce into the stomach at a time.

So there are certain types of carcinoma of the stomach where the capacity is so reduced that it will only hold an ounce or two at a time. In this man no lump could be felt at all; no dilatation, no peristalsis, and the case looked like cancer of the cardiac end of the stomach or the lower end of the œsophagus. I operated upon this man because, although the disease was advanced, he showed great energy, and evidently possessed a good deal of recuperative power, and I thought an operation was justifiable. We found that nearly the whole stomach was occupied by growth; it was one of those cases in which the growth was not a large irregular mass, but a smooth infiltration of cancer throughout the wall, that condition which is known as the "leather-bottle stomach," in which the capacity is reduced until it will hold only an ounce or two. That was, more or less, the condition in this man. At the extreme cardiac end, however, there was free area on the anterior wall. With much difficulty involving pulling and tugging on the stomach, and by a long transverse incision right through the left rectus and through the abdominal muscles I was able, by having the ribs held well up, to obtain access to this portion of stomach, and to make an anterior junction. Though a very anxious case, he did very well indeed for a month or six weeks, gaining flesh and losing his pain. However, the malady quickly advanced, and he lived but four months.

You may ask, Was it worth while operating at all? At the present time I think it is better to leave them alone, but personally one had to learn one's lesson, and it was necessary to get experience so as to be able to form an opinion upon such conditions. I have practically come to this conclusion about the third type, that when the patients are emaciated, when they can take very little food, and when they are sick immediately after taking fluids, and when the taking of small quantities of fluid causes pain at once, that these patients have not long to live, and that on the whole they had better not run the risk of what might be a very dangerous proceeding indeed, but should be relieved by sedatives and such measures. It was the operating upon such a case as that of the man Schenk which especially led me to undertake, within the last few months, two similar cases in Job ward. Both died, one from shock, and the other from loosening of the button. The absence of any palpable swelling in Group 3 is due to diminution in the size of the stomach. In Group 2 this infiltration of the gastro-hepatic omentum prevents the descent of the stomach. Again, the growth is often adherent to the posterior abdominal wall. These two conditions may prevent the descent of the pylorus also in Group 1. Especially, however, in Group 2 is this the case. So that whenever a tumour can be felt in the second type we may be sure the disease is extensive and the case unfavourable. The absence of dilatation may be set down to two causes, *e.g.*, the fact that the pyloric orifice is not completely obstructed, and that only a small amount of food can be ingested at a time.

I have tried to give you, shortly, three clinical groups of cancer of the stomach to consider from the point of view of operation, and I will summarise the cardinal points of these three groups. In the first there is dilatation and peristalsis, and a mass palpable in most; and I ought also to add, that the mass is movable when typical.

In the second group a central mass can be felt, but there is, as a rule, no dilatation and no peristalsis.

In the third group there is a practical absence of palpable signs. There is a long history, evidence of a diminished capacity, in pain, and sickness following soon after the taking of food. The clinical symptoms in this group closely resemble stricture of the lower end of the œsophagus.

You will, of course, infer without any statement of mine, that the prognosis as to operation depends upon the extent of the growth. The results of the palliative operation in the first group are very favourable. In pyloric cancer the main symptom is obstruction. The patients do not till a late stage suffer from the cachexia of cancer, and for this reason, the cases being purely obstructive, they are closely allied to the cicatrization of a simple ulcer. And in those cases you can operate quite freely. Another

reason why they are suitable for operation, and a very important reason indeed, is that the stomach being dilated is easily handled. In performing gastro-enterostomy, the colon is brought out of the abdomen and laid upon the ribs, an opening is made in the meso-colon where the vessels are absent, and the stomach drawn through. There is no pulling upon the sympathetic plexus, a most important matter in diminishing shock.

Operation is difficult in the second group, and dangerous or impossible in the third. It is difficult because in drawing the stomach through the meso-colon there is injury to the nerves and increased shock. It may be impossible, because the stomach may be so much involved that there is not sufficient surface to deal with. In one case, on opening the abdomen a typical leather-bottle stomach was found and the operation abandoned. Handling of the stomach produces shock, and where the stomach is so extensively involved that the transverse incision must be added to the vertical, and where only a small portion of stomach is free we had better leave the case alone. These patients do not live very long, and I have practically made up my mind not to proceed with the operation on finding the disease so extensive, for although one has been successful in helping those cases a great deal, some have died from shock.

If you open the abdomen in these cases you must select the kind of operation. What is the best for the case? Whenever it is possible we must do posterior gastro-enterostomy. This when properly executed is quite successful; never gives rise to any regurgitation of bile, and requires no special means to prevent that regurgitation, such as making a flap through the wall or uniting the two limbs. Simple junction made in the right way, as shown in the diagram, is enough. But in groups 2 and 3 it may be unwise or impossible to make a junction from the back owing to the fixation of the stomach. If the operation is to be completed in such a case it is better to make the junction on the anterior wall than to add the extra strain which would be thrown on the patient by dragging the stomach through the transverse meso-colon.

There is another reason besides this difficulty in the operation itself which taxes the endurance. In Groups 2 and 3 the strength of these patients has been sapped by the spread of the disease; it is not a condition of simple starvation, as in the pure pyloric cases, there is also the cachexia caused by the systemic effect of the cancer, a very important matter to bear in mind and to estimate. Recently in probably two cases, certainly in one, judgment was wrong on that point. One man was a bronzed healthy-looking countryman, and I was misled as to his powers of endurance. We must therefore look upon operation in the presence of wide involvement of the stomach and secondary deposits in the peritoneum, as carrying a greatly increased risk. Moreover, if completed in the most extensive cases little benefit may result. We had an instance of this lately when in the presence of malignant ascites and advanced disease the operation was successfully carried out.

I must now say a word or two about the curative operation, or excision. Of some forty cases there were only three in which excision was possible. In all three so large a portion was removed that union with the duodenum was impossible, and a gastro-enterostomy was necessary. Two survived, one living about a year, the other, operated upon a few months ago, is present to-day for inspection. The third died after operation.

The specimen from the woman attending to-day represents a good third of the stomach. In the other two as much or more was removed. Even carrying the section one and a half inches wide of the growth will not always clear the lymphatics in the wall. These vessels run upwards towards the œsophageal end, and show wide infiltration even where the mass is small.

This is an important question in considering excision of gastric cancer, and it seems to me to dispose altogether of the operation of pylorectomy, that is to say, cutting out the pylorus with the growth and bringing the stomach and duodenum together. That operation will, I believe, be less and less performed. It has always seemed to me that the section

was too near the growth, much nearer than we should consider wise in operating for cancer elsewhere.

It is better to perform gastro-jejunestomy and remove the growth freely. I found such a large gap in my first case, now some six years ago, that it was impossible to unite the parts without undue tension on the stitches. Therefore I brought the stomach out through the omentum and did a gastro-enterostomy in the usual way. The immediate result was excellent, but he lived only a little over a year.

The woman here to-day tells me she can eat anything; in fact she is rather poor and says she could eat more than she gets. No doubt the operation does check the disease to a certain extent, but one wants to be sure of being able to remove the whole of the disease before attacking it. Still, as in the instances I have narrated, we may not be able to recognise the full extent of the disease until we have divided the stomach and turned it over in order to ascertain this important fact. I have ligatured and cut through the great omentum, and then turned the stomach up and examined the posterior wall in the neighbourhood of the pancreas, and, finding glands involved in that position thought it unwise to submit the patient to the larger operation. I may say that this operation of excision *qua* shock is not at all serious. I do not think anybody looked better the day following operation than this woman did. She was relieved of most of her symptoms, and was able to take food very well, and picked up condition with astonishing rapidity. So that if you have not to do with cancerous cachexia you need not fear excision on account of the shock. If the evidence on that point is sufficient, it comes to this: What is our duty with regard to these cases? That, after all, is the great point. And how are we going to advance in our treatment of these cases? Our only chance, as in all cancer, is to get the cases early. We shall have to submit them to exploration without waiting for the evidence of a large mass; for when that evidence appears, probably the case is too late to be successfully dealt with. We must get our cases early.

Another important point is one which I called your attention to last time. In thinking that these symptoms may be due to growth, you must have been struck with the age of some of these cases of cancer of the pylorus. One was only thirty-four years of age. On the other hand, you have to remember, as I pointed out last time, the advanced age of some of the cases which had simple obstruction; I mentioned a woman of fifty-two, and men of sixty-two and sixty-three who had simple obstruction. So if we get a man of that age who is wasting, has dyspepsia, and some dilatation of the stomach, we are not justified in condemning him as a malignant case. On the other hand, if we get a man of between thirty-five and forty-five with these symptoms we are not justified in concluding that it is necessarily a simple condition. We shall have to operate upon these cases very much earlier; that is the only way we can advance at all.

If we contrast the value, as regards comfort, and as regards life, of gastro-enterostomy and excision, where shall we find ourselves? I should put it in this way: that unless the whole of the growth be removed, including the glands and the infected lymphatics in the stomach, the duration of life is not much greater after excision than it is after a simple gastro-enterostomy. Of course that is founded upon a very small amount of information. But as our knowledge increases and we get more cases in the early stage, we may be able to say that the duration of life will be very much increased after gastrectomy.

I have already mentioned what I think would be the best method of excision, the actual details I need hardly go into, except to say that the stomach is very rapidly closed by a first suture which goes through all the coats, leaving little bits of mucous membrane exposed, and by a second continuous Lembart suture. It is very quickly done. Gastrectomy does not add more than half an hour to the gastro-enterostomy.

I have put before you these cases of cancer of the stomach rather to give you grounds for forming an opinion upon the value of operation, and in what class of case you will be justified in recommending that it shall be done.

The Pathology of Chorea.

By Kenneth Black.

Awarded the Treasurer's Prize by the Physical Society.

"Speak freely what you think."

The subject of this essay is of deep interest, and has engaged the attention of pathologists and physicians from early times. In the light of the recent researches into the bacteriology of rheumatism and chorea, the pathology of chorea becomes less obscure, and the facts of the disease less difficult to comprehend. In this essay the present position of our knowledge of the subject will be stated, the morbid anatomy first described, and the site of the lesion and the theories of its pathology then considered.

In the first place it will be necessary to have a clear idea of what is meant by *chorea* (Gr. χορεια, a dancing), a disease named variously chorea minor, Sydenham's chorea, St. Vitus's dance, chorea anglorum, and chorea vulgaris. Dr. Osler[1] defines chorea as a "disease chiefly affecting children, characterised by irregular involuntary contraction of the muscles, a variable amount of psychical disturbance, and a remarkable liability to acute endocarditis." There are various other diseases or disorders of movement, which have been named choreas or choreiform affection, and yet have nothing to do with the definite disease now under consideration. There is chorea major, embracing the dancing mania, and the various forms of rhythmical or hysterical disorders of motion, characterised chiefly by emotional and psychical disturbance; the secondary choreas, which occur after lesions of the motor cortex or path, including the pre- and post-hemiplegic disorders of movement, spastic choreas, congenital choreas, and chronic or Huntingdonic chorea; the choreiform affections, called by the French pseudo-choreas, including the various forms of habit spasm, or tic. But these disorders do not concern us here, and no further reference will be made to them.

It was in 1418 that the word *chorea* was first given to an epidemic occurring at Strasburg of a dancing mania, now named chorea major, the victims being sent to the chapel of St. Vitus, at Zabern, to be cured by religious ceremonies and the influence of the saint, just as in our own time other saints are supposed to possess an analogous power in other complaints. Sydenham,[2] in 1686, first used the word *chorea* to indicate the disease which is the subject of this essay, and which is quite distinct from the chorea major occurring in the middle ages at Strasburg and elsewhere. His account is clear and interesting, and if not full, is well worthy of quotation:—"St. Vitus's dance is a sort of convulsion which attacks boys and girls from the tenth year until they have done growing. At first it shows itself by a halting, or rather an unsteady movement of one of the legs, which the patient drags. Then it is seen in the hand of the same side. The patient cannot keep it a moment in its place, whether he lays it upon his breast or any other part of the body. Do what he may it will be jerked elsewhere convulsively. If any vessel filled with drink be put into his hand, before it reaches his mouth he will exhibit a thousand gesticulations like a mountebank. He holds the cup out straight, as if to move it to his mouth, but has his hand carried elsewhere by sudden jerks. Then, perhaps, he contrives to bring it to his mouth. If so, he will drink the liquid off at a gulp, just as if he were trying to amuse the spectators by his antics. Now this affection arises from some humour falling on the nerves, and such irritation causes the spasm." Sydenham, then, even at this early date, had considered the possibility of a poison causing this disease. From this time onward numerous eminent writers have contributed valuable essays and monographs to Sydenham's first observations, and not a few have come from this hospital. Bright,[3] Babington,[4] Hughes,[5] Lever,[6] Burton-Brown,[7] Wilks,[8] Pye-Smith,[9] Goodhart,[10] and Goodall,[11] have all added classical essays to the literature of chorea, and these are largely quoted by the writers of to-day.

Morbid Anatomy.—The changes recorded in the *central nervous system* are first to be considered. One of the difficulties of the past in the study of chorea has been the absence, for the most part, of any gross or readily ascertained changes in the structures of the nervous system in such cases as have proved fatal. Macroscopic anatomy revealed nothing to the earlier morbid anatomists, and one finds no facts of importance in this disease until the time of Dickenson[12], he discovered certain hyperæmic foci spread very generally over the brain and spinal cord, with dilated arterioles and small hæmorrhages, especially in the basal ganglia. Subsequently Dana[13] found intense cerebral hyperæmia, peri-arterial exudations, erosions, softened spots, minute hæmorrhages and occasional emboli, most marked in the deeper parts of the motor tract, particularly the lenticular nuclei and optic thalami, and states that these changes cannot be regarded as inflammatory. The late Dr. Charlewood Turner[14], in his important papers, described a change in the larger pyramidal cells in the deeper layer of the

1 Osler "Principles and Practice of Medicine," 4th edition, 1902, p. 1079.

2 Sydenham's "Schedula Monitoria," 1686. Published in his works (Latham's Translation). Vol. 2, Sydenham Society's Edition.

3 Reports of Medical Cases, vol. ii., 1831.

4 Guy's Hospital Reports, Series 1, vol. vi., 1841. "Chorea."

5 Guy's Hospital Reports, Series 2, vol. iv., 1846. "One hundred cases of Chorea."

6 Guy's Hospital Reports, Series 2, vol. v., 1847. "Chorea and Pregnancy."

7 Guy's Hospital Reports, Series 3, vol. i., 1855. Hughes and Burton-Brown—"Two hundred cases of Chorea."

8 Wilks, "Lectures on the Nervous System." Second edition, 1883.

9 Guy's Hospital Reports, Series 3, vol. xix., 1874. "Rheumatism and allied disorders."

10 Guy's Hospital Reports, Series 3, vol. xxv., 1881. "Rheumatic diathesis in children."

11 Guy's Hospital Reports, series 3, vol. xxxii., 1890. "Chorea."

12 Med. Chir. Transactions, vol. xli., 1876.

13 Brain, vol. xiii., 1890. "The pathological anatomy of chorea."

14 Pathological Society's Transactions, vol. xliii., 1892, and Lancet, 1892, vol. ii., p. 1134.

cerebral cortex. He found these cells much swollen, opaque, the protoplasm cloudy and readily stained by reagents, in fatal cases of chorea. He also found similar lesions of the nerve cells in cases of nutritive disturbance of the brain from other causes—viz., cerebral plumbism, uræmia, etc.; but never anything approaching the more conspicuous lesions in chorea. These changes, he believed do completely recover, unless the highest grade of swelling was reached. He found no indications of embolism of the small vessels, but conceived that any conditions tending to cause structural lesions of nerve-cells, must tend to cause the like in small vessels supplying them, and so lead to thrombosis. He discussed the relations between these lesions and the clinical features of chorea, and maintained that the latter were indicative of structural mischief in the brain, and not attributable to nutritive derangement with functional inhibition only of the central nervous system, as in the case of hysteria when volition is in abeyance. Dr. Cambell Thompson[15] and Dr. Abrahams[16] have recorded similar changes in the larger pyramidal cells of the motor cortex in fatal cases of chorea. In this connection the recent valuable work of Dr. Mott[17] is important, for the changes recorded by the above observers coincide with his description of degeneration of cortical motor cells. It may be regarded, therefore, that this change in the motor nerve-cells of the cortex in chorea is a retrograde or degenerative one, which is recoverable in the majority of cases. The so-called chorea corpuscles, described by Elischer as centrically laminated bodies attached to the blood-vessels in the corpora striata and internal capsules, are in no way characteristic of chorea, as was pointed out by Wollenberg, who found them present in many non-choreic brains. Therefore a consideration of the changes in the central nervous system in chorea, is suggestive, in the light of recent investigations, of some organic lesion in the motor cells of the cerebral cortex, although the evidence is by no means conclusive.

Cardiac changes, now to be considered, are present in almost all fatal cases of chorea. Of these, endocarditis seems the most important, perhaps on account of its more easy detection. Dr. Sturges[18] records the heart healthy in only five out of eighty necropsies. Dr. Osler[19] found sixty-two out of seventy-three with recent endocarditis. Dr. Goodhart[20] gives endocarditis as absent only once in his thirty cases. It is remarkable that with no disease, not excepting rheumatism, is endocarditis in fatal cases so constantly associated than with chorea. Incidentally it may be remarked that the vegetations on the valves in chorea have been said to differ in character from those occurring in rheumatism. Pericarditis occurs in some cases, and was first described by Bright,[3] who also states that this had long been observed by Guy's Hospital physicians. He thought the connection between chorea and pericarditis was through the phrenic nerves, which communicated the irritation from the inflamed pericardium to the spinal cord. Dr. Osler[19] records pericarditis present in nineteen out of his seventy-three cases. Myocardial changes seem not to have been investigated until quite recently, when Dr. Poynton[21] found microscopical changes in the heart wall in chorea similar to those occurring in diphtheria and acute rheumatism, and he concluded that this was due to a direct toxic action on the heart. The heart, therefore, shows almost invariably some marked lesion in fatal cases of chorea, and this is a most important factor in view of the theories of its pathology and of its connection with rheumatism.

Besides the changes described in the nervous and cardiac systems, there are general changes occurring in fatal cases of chorea to be briefly stated. After death there are frequently bruises and excoriations about the body externally; in cases of long duration the body is much emaciated, while in acute cases with fever the appearances are those of a person dead of an infectious disease; the skin is congested, the blood is dark, and the muscles are of a very red colour.

SITE.—The site of the lesion giving rise to the specific symptoms of this disease is certainly in the central nervous system. When it was discovered that frogs could perform co-ordinated movements after removal of the cerebrum, it was natural that chorea should be referred to disorder of the spinal centres. Thus Romberg, writing in 1851, placed chorea minor among the "spinal spasms," and in 1873 Jaccond upheld a similar doctrine. In support of this view Chauveau found, by experiments on dogs having choreiform movements, that if the spinal cord is divided close to the skull, the movements do not cease, and if again the cord be divided in the lower dorsal region, artificial respiration being performed, the movements stopped. These experiments have been repeated and confirmed by others. Sir Victor Horsley,[22] however, points out that canine chorea is not identical with the disease in man, and that even if it were so, there remains the question whether or not in the human subject the higher nervous centres do not assume functions which in animals are performed by lower ones.

The facts of chorea all point to the seat of the lesion being the cerebrum, the commencement often in one limb and spreading to the others, the cessation of the movements during sleep, their increase during emotion, the degree of control of the movements being maintained by the will, the intense psychical phenomena in the more serious cases, and the mental features and alterations in character in the less severe forms. Then again *toxic* not *clonic* spasm is characteristic of spinal

15 Lancet, 1899, vol. ii., p. 456.

16 Trans. Pathological Society, vol. li., 1900. "The cortical changes in acute chorea."

17 Lancet, 1900. Croonian Lectures. "Degeneration of the neurone."

18 Sturges, "Chorea," second edition, 1893.

19 Osler, "Chorea and Choreiform Affections," 1894.

20 Goodhart and Still, "Diseases of Children," seventh edition, 1902.

21 Lancet, 1900, vol. i., p. 1352. "A study of the heart wall in diphtheria, rheumatic fever and chorea."

22 Lancet, 1886, vol. i., p. 54.

irritation; and there is the fact insisted on by Sir William Broadbent[23], and previously observed by Romberg, that tickling the palm of the hand or sole of the foot of a child affected with chorea, leads to no increased spasms, as one would expect if the lesion were in the spinal cord.

When the corpus striatum was thought to be the great centre for muscular movement, the lesions of chorea were sought for in its neighbourhood. Charcot and Raymond even went so far as to locate the lesion, as in hemianæsthesia, in the posterior part of the internal capsule, but more especially upon some bundles of fibres lying just in front and to the inner side of those whose injury produces hemianæsthesia, and which are in contact with the posterior extremity of the optic thalamus; they believed these lesions to be hæmorrhages. Bastian has shown that this particular region has independent blood supply.

Of course irregular movements of muscles may be produced by irritation in any part of the motor path, but as Sir William Gowers[24] has pointed out, the motor impulses that excite the muscles pass to the spinal cord from the motor region of the cortex. It is here that movements are arranged, and if they are disarranged and the disorder proceeds from the brain, it is naturally referred to a disordered action of the cells of the cortex. He thinks it doubtful that there are any facts at present to justify us in going beyond the motor cortical cells in our search for the primary disturbance. Many of the objections to the other proposed localities do not apply to the motor cortex, partly, perhaps, because its functions are still imperfectly known. It will therefore be preferable, in accordance with modern views, to look upon the cortical motor centres as the seat of the main disturbances of movements in chorea; and this is further supported by the recent work of Dr. Turner[14] and Dr. Mott[17] already referred to.

PATHOLOGY.—Coming now to the true pathology of chorea, there are three chief theories that have to be considered. There is the *embolic theory*, originally advanced by Kirkes fifty years ago and obsolete; the functional theory with its numerous supporters; and the infective theory, implying that there is some infective or toxic agent bringing about a pathological change in the brain, resulting in the specific symptoms of chorea. It must, however, be pointed out that this last theory does not necessarily imply that chorea is rheumatism of the brain, although many of its supporters are of that opinion.

Considering first the *embolic* theory – that chorea is due to embolism of the smaller cerebral arteries of the cortex, leading to local anæmia, malnutrition and degeneration, and thus loss of control over the muscles—due, it was believed, to minute vegetations being washed off the diseased valves of the heart. This theory was suggested by the almost invariable presence of endocarditis in fatal cases, and the finding in some cases of embolism of the smaller cerebral vessels. The supporters of this theory, including Dickenson and others, urged that chorea was not uncommonly limited to one side, and then generally was right sided; they explained this on the ground that the blood current to the brain is more direct on the right side than on the left. Then also in capillary occlusion of the brain lies a rational explanation of the imbecility which so often accompanies the disease; and further, in this connection there are the researches of Dr. Mott,[17] already referred to, who finds that when the blood supply is cut off, there is a degeneration of the nerve cells, which is recoverable in the slighter grades. Further, there are the experiments of Rosenthal and Money on animals, the signs of chorea being produced by injecting fine particles into the carotid artery. Against this theory it is denied that hemi-chorea is more often right-sided by Dr. Sturges[18] and Dr. Pye-Smith,[9] and further it is rarely entirely one-sided, it may start on one side, but usually becomes general although it may be more marked on one side than on the other. Then again the organic heart murmur is often developed late in the course of the chorea, and unless one assumes that the endocarditis is present without any murmur, this is strong evidence against this theory, that is against the emboli coming from the valves. Furthermore, in adults both endocarditis and embolism of the cerebral vessels are comparatively common, yet chorea in them is very rare, and even in children endocarditis is common, yet chorea is comparatively infrequent. These and other important considerations to be presently enquired into, seem inadequate to support this theory, although one must admit that at first sight it looks reasonable.

The *functional* theory of the cause of chorea is that the brain is disordered not diseased, that the "disease" is an exaggeration and perversion of the action of natural nerve-muscular mechanisms. Dr. Sturges[18] defined chorea as "consisting of an exaggerated figgetiness," in other words, to an instability of the nerve-cells, brought about, one supposes by hyperæmia, another by anæmia, a third by psychical influences, and a fourth by irritation, central or peripheral. Handford[25] believes the essential cause of chorea is vascular engorgement of the nervous centres due to emotion, in support of which he cites fatal cases where hæmorrhages and thromboses were found. Dickenson also has expressed the opinion that the condition is due to "a wide-spread hyperæmia of the nervous system." Emotion is, from clinical experience, a factor in the ætiology of chorea, and this is also a definite cause of vascular excitement, as shown in the form of cardiac palpitation and blushing of the skin, and it is no great assumption to suppose that the parts that cannot be seen blush and become hyperæmic also. The converse of hyperæmia affords a possible explanation of the movements, for anæmia of the brain, as has been pointed out, causes a degeneration of the nerve-cells. There can be little doubt that in all so-called "functional" diseases there is some underlying molecular or chemical change in the neuron, although as yet we are ignorant of the

[2] British Medical Journal, 1869, vol. i., p. 86.
Gowers, "Diseases of the Nervous System," 1893, vol. ii.

[25] Brain, vol. xii., 1890.

precise nature of such changes, and in the present imperfect state of our knowledge all those diseases in which no determining pathological cause or lesion can be found are classified as "functional," and chorea is still placed in text-books among the functional diseases of the brain.

The recent work of Dr. Mott in association with Professor Halliburton[26] is most valuable and instructive; they found in general paralysis of the insane and several other degenerative nervous diseases choline in the blood. Dr. Mott is of opinion that the test of the blood for choline will therefore help in diagnosing between organic and functional nervous diseases. This seems a doubtful point for all diseases in which there is some change in the nerve-cells are degenerative; one cannot conceive a pathological change in a cell being anything than a retrograde, that is a degenerative one, although it may only be temporary and may not attain a degree that can be discerned by the microscope.* If chorea is to be regarded as due to a change in the motor nerve-cells of the cortex, this change is a degeneration; yet chorea is not considered, in the same way as in the case of general paralysis of the insane, a degenerative disease.

In support of the functional theory there is the fact that an excitable and restless child may often be seen to make movements like those of chorea, suggesting that the choreic spasms are physiological; on the other hand, there are in most cases of chorea symptoms which precede the onset of the spasm, and in some cases the spasms are in abeyance and the general condition of the patient not accounted for by any exhaustion that may have been produced by excessive muscular action. This theory is also supported by the antecedents of the child, both parental and individual, in the facts of the disease itself, in the want of control, the emotional excitement, its frequency in girls and occurring at a time when the development of the brain is advancing rapidly, its cessation during sleep, and its all but certain tendency towards recovery. Against this theory there is the overwhelming evidence of the association of a heart lesion, which so often develops during the course of chorea, the intimate relation to rheumatism, and in a few cases the fatal termination. These and other facts presently to be considered indicate that the mere instability of the nerve-cells is but a part of the disease.

The *infective* theory of chorea has been discussed by many, especially in connection with acute rheumatism, the cause of which is almost proved to be due to an infective agent. There seems to be in the facts of chorea evidence enough to prove that the causative agent is the same or allied to that causing acute rheumatism. In considering this theory the bacteriology first claims attention, and the clinical facts of chorea afforded by a study of the ætiology, onset, symptoms, termination, prognosis and treatment will then be considered, pointing out the relation with functional and infective diseases, more especially with rheumatism.

[26] British Medical Journal, 1901, vol. i., p. 789.

* It must be clearly understood that morbid growths are made up of *new* cells, and therefore do not come under this category.

In *bacteriology* will most probably be found the true pathology of chorea, and many attempts have been made to isolate micro-organisms in this disease. Naunyn found a cladothrix on the meninges and in the endocardial vegetations in a fatal case. Berkeley found the staphylococcus pyogenes aureus in the heart-blood in a fatal case of chorea. Triboulet has found staphylococci after death and also in the blood during febrile attacks. Pianesse, of Naples made a very exhaustive research on the subject, and claimed to have isolated a bacillus from the nervous system of a choreic patient, which he was able to cultivate successfully, and which, when inoculated into animals, caused their death with muscular twitching and convulsions, and from these animals the same bacillus was obtained in pure culture from the central nervous system. Maragliano, who regards the bacillus of Pianesse as the bacillus coli communis, believes that chorea is due to the action on the nervous system of the toxins of various micro-organisms, notably the toxins of staphylococci.

Dr. Poynton and Dr. Paine[27] isolated a diplococcus in pure culture from the joints, pericardial effusions, inflamed valves, subcutaneous nodules and blood in cases of acute rheumatism; they also isolated from the throats of living patients with rheumatic tonsilitis this diplococcus. These observers produced, by inoculating this organism into rabbits, inflammation of the heart-valves and joints in some and a condition resembling chorea in others, and in this quasi-chorea they found the same diplococci in the pia mater and in the endothelial cells of the blood capillaries dipping into the motor cortex from the surface. Wassermann, Malkoff and others have found dipplococci in the meninges and cortex in fatal cases of chorea. Singer, of Vienna who holds, the view that rheumatism is a form of attenuated pyæmia, his researches having disclosed the constant presence of pyogenic organisms in that disease, and who regards the diplococcus of Poyton and Paine as the streptococcus pyogenes, in a fatal case of chorea isolated the staphylococcus aureus, but it is important to note in this instance there was pus in one elbow-joint.

We now come to the important result of the researches of Dr. Beaton[28] and Dr. Ainley Walker[29] conducted at this hospital. They find that a micrococcus is constantly associated with rheumatic lesions, and believe that this organism is the causal agent in the production of rheumatism. They state that this organism is a tiny micrococcus arranged in pairs and short chains in films from ordinary subcultures and is identical with the organism that has been classed by Poyton and Paine as a diplococcus and by the German workers usually as a streptococcus. They also decide that this micrococcus is specifically different from the ordinary pyogenetic streptococcus of human origin. They obtained from three cases of chorea—from the urine in one, and from the

[27] Lancet, 1900, vol. ii.

[28] Beaton and Walker, "The Etiology of Acute Rheumatism and Allied Conditions." British Medical Journal, January 31st, 1903.

[29] Walker, "The Micrococcus of Acute Rheumatism." Practitioner, February, 1903.

post-mortem blood of the heart in the others—a micrococcus identical with that which causes acute rheumatism, which, on injection into animals, produced a typical attack of acute rheumatism, but not true chorea, although a number of quite young animals were used. This last fact is explicable, I believe, on a want of susceptibility that undoubtedly exists in lower races and animals, for chorea is a disease essentially of civilised man. We know that the organism producing Mediterranean fever (micrococcus melitensis) can exist in the body as a micrococcus or diplococcus, and in cultures as a staphylococcus, and it is probable also that the organism of Poynter and Paine exists under different conditions as a micrococcus, diplococcus and streptococcus. It may be concluded that, as the bacteriology of chorea minor is at present *sub judice*, the evidence that this disease is caused by an organism is not final although probable in the light of recent research.

The clinical facts of chorea must now be investigated, and these not only afford strong evidence in favour of the infective theory but suggest that the causative agent is closely allied to that which causes acute rheumatism.

The *ætiology* of chorea appears at first sight to favour rather the functional than the infective theory, but on closer investigation the doubtful facts can be satisfactorily explained by some infective agent. Chorea is a disease that affects civilised nations, and is practically, as pointed out by Dr. Osler, unknown in the black races, although they are liable to have rheumatism. This rarity of chorea amongst the dark races may be due to their less highly developed, and therefore less susceptible nervous systems; there is a parallel, pointed out by Dr. Mott,[30] in the action of syphilis in producing general paralysis of the *in*sane in civilised man, for in the savage races syphilis is common, while general paralysis of the insane is very rare.

The distribution of chorea in the United Kingdom has been investigated[31] and found to correspond more with that of rickets than with rheumatic fever, which latter is more widely distributed, whereas chorea and rickets accumulate in the great industrial centres, the rural districts being comparatively free. The different conditions of life in children living in town and in the country are surely sufficient to account for the variations in the distribution of chorea, a disease in which mental effort, fright, and school pressure bear so important a part.

The prevalence of chorea has been carefully investigated by Dr. Fletcher[32] in its connection with rheumatism, and the seasonal relationship is marked; the maximum number of cases of chorea occurring in December, January and March, that is to say, in the months following the period of greatest prevalence of acute rheumatism—*i.e.*, in October and November. He considers this frequency of chorea in December, January and March is very largely dependent on the prevalence of rheumatic fever in November and December.

The age incidence of chorea differs from that of rheumatism, the former occurring from five to fifteen, an age when the brain is most susceptible to disturbances of function, whereas the latter occurs generally between the ages of fifteen and thirty-five.

The sex incidence is instructive, for in chorea, as would be expected, females are more often affected, the proportion to males being three to one; whilst in rheumatism males are more often attacked than females in the proportion of about three to two, but under the age of twenty this relation in rheumatism is reversed and agrees with the sex incidence of chorea.

Impoverished states of health unquestionably have a marked influence on the development of infective diseases by rendering the individual vulnerable to micro-organisms or toxins. The chlorosis, for instance, occurring in girls at puberty, is said by Trousseau[33] to play an important part in the ætiology of chorea.

Neuropathic heredity is an important factor in the causation of chorea, hysteria, insanity and epilepsy being most common, and it is in families where neuropathic and rheumatic heredity are met with together, that the incidence of chorea seems to be greatest, suggesting that the disease is due to some infective agent superadded to functional disorder.

A choreic patient may become pregnant, but more commonly a pregnant woman has an attack of chorea. This is no doubt due in the main to emotion, which seems essential for the development of chorea; and this is supported by the fact that it is more common in first pregnancies, when causes for anxiety are greatly multiplied, and, as Sir Samuel Wilks has pointed out, in unmarried girls who become pregnant. Trousseau ascribes this connection with pregnancy as due rather to the anæmia, which so frequently accompanies pregnancy, than to the emotion. It is questionable whether the chorea of pregnancy is the same as that occurring in children.

Chorea has been stated to follow infective diseases, but the relation seems very remote except in the case of acute rheumatism where the connection is very real and apparent. Excluding rheumatism, scarlet fever is the most important infection, yet this only precedes chorea in a little more than half per cent. of the cases. More than a century ago William Heberden noted that chorea had been preceded by a "stiffness and pain in the knees." It is to Bouteille that the credit is given for first pointing out, in his essay on chorea published in 1810, the association of rheumatism with chorea: but Bright had in 1802 clearly recognised this relationship. Hughes[5] was the first to publish statistics on this relation; but Sée and Roger did most in establishing the relationship between these two diseases, Roger even regarding articular rheumatism, endocarditis and chorea as different names applied to one and the same pathological condition. The

30 Lancet, 1902, vol. ii., p. 525.

31 Isambard Owen. Trans. International Congress, Washington, vol. v., p. 157.

32 St. Bartholomew's Hospital Reports, vol. xxxii., 1896.

33 Trousseau's Clinical Medicine, vol i. Bazire's Translation, 1868.

extent and significance of this association have been variously estimated. Tylden gives the largest number of cases of chorea with preceding rheumatism, which he found to be fifty per cent., and in those cases with some rheumatic history, family or personal, he gives seventy-two per cent. Others give lower figures—Hughes[5] twenty-five per cent., Sée forty per cent., and the Collective Investigation Committee of the British Medical Association twenty-five per cent. with preceding rheumatism. This seems all the more suggestive when the age incidence of the two diseases is remembered, for the age period of rheumatism occurs subsequently to the age period of chorea. Dr. Goodhart[20] insists on the fact, too frequently overlooked, that the previous occurrence of rheumatism in the child or in its family is only part of the evidence in favour of the rheumatic nature of chorea, in many cases the chorea is the first symptom of rheumatism, and the further evidence of rheumatism appears later. Dr. Batten's[34] figures throw light on this point. He found that out of 115 cases of chorea treated at the Great Ormond Street Hospital there was a previous history of rheumatism in 37, that is in 32 per cent., and none in 78. He followed up these 78 cases three years later and found that of 57 recorded, 13 had developed rheumatism, bringing the percentage up to 43·5. Three years later, that is six years after the first observation, of the remaining 44 cases only 29 were traced, and of these 10 had developed rheumatism and 1 had died of heart disease, showing that in spite of the impossibility of tracing all the cases no less than 53 per cent. of the original number had now shown evidence of rheumatism as against 32 per cent. which had had previous rheumatism at the time of the chorea, six years previously. Furthermore, the intimate connection between these two diseases is clearly shown by the relationship existing between chorea and diseases of the cardiac valves, already mentioned, and also by the facts that not uncommonly chorea immediately follows acute rheumatism, that slight choreic movements appear in the course of the rheumatic attack, that the latter occasionally comes on in the course of chorea, as evidenced by a slight fever with pain and swelling of the joints. It is this intimate connection between these two diseases that is so suggestive that the causative agent of chorea is closely allied, if not identical, to that of acute rheumatism.

The exciting cause of chorea in many cases cannot be traced, but where it is present it is generally of an emotional character, such as a shock or fright; and Dr. Mackenzie[35] finds this present certainly in 50 per cent. of the cases. Dr. Goodhart[20] is disposed to think that one frequent cause of fright or nervous shock in children, liable to be overlooked, is nightmare. An important cause of mental exhaustion and shock, not to be overlooked, is peripheral irritation, such as from an erupting or decayed tooth, intestinal worms, eye strain, or other local malady. Sir William Gowers points out that fright was the apparent cause of chorea in a rather larger proportion of the patients who had had rheumatic fever or preceding heart disease. This relation of shock to chorea is analogous to the relation of the exciting cause to rheumatism, which is generally found to be exposure to wet or damp. Everyone is familiar with the rheumatic subject who, by sleeping in a damp bed or by getting wet through, develops an acute attack, suggestive that the infective agent is already present in the system and merely requires an exciting cause to produce the attack. Probably all of us entertain unconsciously hosts of micro-organisms, and the effects of shock, whether due to injury, chill or emotion are to lower the vitality and powers of resistance and so to start a disease. Shock is well known to be an important exciting cause of the infective disease, puerperal septicæmia.

Imitation was formerly regarded as an exciting cause but it is very doubtful that chorea is ever contracted in this way. Dr. Lees[36] states that "if a child in the rheumatic state is exposed to chill or wetting of the limbs, arthritis will follow, but if to a mental (cerebral) shock, chorea."

Many children are exposed to emotional disturbances and yet a very small percentage develop chorea, and in the study of the ætiology of the disease it seems probable that there is some further agent at work acting on an existing weak brain, congenital or acquired, which has been rendered potent by the resisting power of the nerve cells being further lowered by an emotional disturbance, which therefore undergo a pathological change.

The *onset* of the disease favours the infective theory for it is rarely sudden, generally premonitory phenomena occur which often escape notice, and thus induce the belief that the choreic movements developed themselves at once. These prodromata consist in impairment of the intellectual faculties; the child's temper changes and he becomes irritable and restless. Generally also the patient complains of malaise, of headache, of vague pains in the limbs, and of præcardial anxiety. The digestive functions lose their accustomed regularity, the appetite diminishes, digestion becomes more difficult and is attended by constipation. The convulsive agitation is already announced by a wish to move constantly from place to place, and by uneasiness in the limbs; this agitation becomes more and more marked, and lastly, the choreiform movements manifest themselves, usually on one side and spreading to the other, but in rare instances they may remain localised on one side. There is generally an interval, rarely more than seven days from the immediate cause of the attack to the commencement of the movements.

The *symptoms* afford evidence to support the infective theory. Considering the movements and paralysis occurring in chorea, one finds that there is almost always some paralysis—*i.e.*, loss of power in the limbs most affected with the movements; the arm, for

34 Lancet, 1898, vol. ii., p. 1195.

35 Report of Collective Investigation Committee of the British Medical Association. Enquiry No. II., prepared by Mackenzie. British Medical Journal, 1887, vol. i., p. 429.

36 British Medical Journal, 1896, vol. i., p. 73.

instance, which is the one most convulsed, is the one also in which muscular strength is most diminished; the patient, a child, often complaining that this arm is heavier than the other. This paralysis disappears almost always simultaneously with the chorea, but it may in some cases persist after it. It may be thought that this loss of power is due to muscular exhaustion, and no doubt it is in many cases, but in some the motor centres are so deeply affected as to lead to paresis of the limbs, which is a more marked feature than the movements; or a true paralysis and not merely a diminution in the muscular strength, may in rare cases precede the manifestation of convulsive phenomena. These paralytic conditions may be analagous to those which occur in typhoid fever and certain other of the infective diseases. In the most severe cases there may be, as Dr. Guthrie[37] points out, complete paralysis from head to foot with rapid wasting and marked mental symptoms.

The disorders of sensibility are rarely constant in chorea. Vague pains already referred to, which, after announcing the invasion of the disease, persist when it is fully developed; to them are superadded a sensation of formication, of tingling, and more or less marked anæsthesia, which is always greater on the more convulsed side.

Transient optic neuritis has been observed by Sir William Gowers,[24] occurring in chorea and passing away on recovery, and he regards this neuritis as related probably to the cause of the chorea rather than directly to the morbid process in the brain.

Dr. Gordon[38] describes a common peculiarity of the knee-jerk in chorea, the leg is quickly raised on tapping the patella tendon, but slowly falls, and he states that this phenomenon is absent in other diseases of the brain. In some cases the knee-jerks are absent and Dr. Lees[39] suggests that this is the effect of a blood poison acting on the involved centres of the spinal cord, secondarily to its action on the brain.

At the outset and in the earlier stages there is not uncommonly some pyrexia, but it is only in the severe maniacal cases that this pyrexia is marked. This absence of pyrexia, for the most part in cases of chorea, does not exclude the possibility of an infection, for it is conceivable that the causative agent producing the degeneration of the motor nerve cells does not involve the termogenetic centres; and furthermore, there is some evidence to show that the lesion is generally unaccompanied by inflammatory reaction. One may encounter undoubted cases of true rheumatic fever in which there may be no other symptoms than the pyrexia, and possibly a slight degree of cardiac dilatation, which may pass unrecognised if not carefully looked for. Precisely the same happens in cases of chorea, with the special supervention of the motor disturbances. Many cases have been recorded in which some infective disease, such as scarlet fever, measles, or acute rheumatism, has developed during the course of chorea, and in these the choreic movements have been suspended during the fever. Hippocrates said that spasms might be arrested by acute fever.

The heart condition in chorea has now to be considered, and this has an important bearing on the pathological aspect of the disease. It is to Addison that the credit belongs of first drawing attention to the frequency of cardiac murmurs in chorea. Hæmic murmurs are herein excluded from consideration. Sir William Gowers[24] finds that cardiac disease is present, either before or during the attack in a third of the cases in which there is no history of rheumatic fever, while in those with such history there is heart-disease in three-fourths. It has been suggested that the endocarditis is always due to some pre-existing rheumatism, but this in many cases will not be confirmed by investigation, inasmuch as the organic bruit so often develops during the attack of chorea. When the cardiac disease is considerable and the chorea of short duration, and especially if the walls of the heart present evidence of consecutive changes, one is justified in assuming that the heart-disease preceded the chorea, and this assumption is rendered more probable if there has been a preceding attack of rheumatic fever. Sir William Gowers[24] records forty cases of chorea with organic heart-disease, in only eighteen of which was there evidence that the endocarditis preceded the attack of chorea, but, as he points out, from the nature of the investigation, only conclusive evidence being admitted, this proportion is below the actual facts, and he states that probably in about half the number of cases of chorea in which there is evidence of organic disease of the heart, this develops during the course of the chorea, and this view is borne out by the experience of others. With regard to those cases in which the endocarditis preceded the chorea, Dr. Frederick Taylor's[40] observations are well worth repetition. He states that besides rheumatism and chorea "endocarditis is the result of other poisons, such as those of pyæmia and scarlet fever; and there are other convulsive disorders which are not explained by the morbid anatomy of the nervous system, but which are the result of poisons, namely, hydrophobia and tetanus.* Moreover, there are some points of close resemblance between hydrophobia, tetanus and acute fatal chorea. For instance, the involuntary muscular contractions in all three, obviously arising from disordered function of the central nervous system, the short duration of the illness. the rapid exhaustion, the mental symptoms in hydrophobia and chorea, and the rapid emaciation in the same two diseases." He also states that in these three diseases the movements stop about eighteen or twenty-four hours before death. Again, general convulsions are also seen as a result of the toxins of uræmia and various fevers. The convulsions of chorea, therefore, have a parallel in the convulsions of other diseases, that are

[37] Lancet, 1901, vol. i., p. 1208.
[38] Lancet, 1901, vol. i., p. 765.
[39] Clinical Journal, March 8th and July 12th, 1893.
[40] Art. on Chorea, Gibson's Text Book of Medicine, vol. ii., 1901.

* Dr. Mott has recently shown that tetanus causes a degenerative change in the motor cells of the cerebral cortex.

undoubtedly infective in origin, and require a stimulus to start them, just as the poison of tetanus or strychnine requires a stimulus to start the series of movements, and in chorea this stimulus is supplied by some emotion, grief, shock, fright or reflex irritation.

In the presence of endocarditis developing during the attack of chorea, there is conclusive evidence that the disease is not functional, unless, as has been suggested, the endocarditis is regarded as produced by an altered blood state brought about by excessive muscular action. This is very improbable, for the organic heart murmur may develop previous to the muscular spasms, or where they are but slightly marked, and other affections, attended with excessive movement, do not produce endocarditis.

Further evidence of the rheumatic nature of chorea is the presence of nodules, first pointed out by Megnet of Lyons, in 1875, observed occurring in some patients suffering from chorea, and similar to the nodules met with in rheumatism. Sheele observed these nodules to occur with chorea, and to disappear with the decline of the attack. Dr. Goodhart and Dr. Still[20] record sixteen out of one hundred and twenty-four cases of chorea, without concurrent articular rheumatism, in which these subcutaneous nodules developed.

The condition of the urine is interesting; there is an increased amount of urea passed, explicable by excessive muscular metabolism, and the chlorides, as in fevers, are decreased in many cases. The most important change, however, is the presence of urohæmatoporphyrin, which Dr. Garrod[41] found in abundance in fourteen out of twenty cases of chorea. McMunn[42] described this substance as very constant in the urine of patients with acute rheumatism, and some other morbid conditions, and this statement has been confirmed by Le Nobel of Leyden, and also by Dr. Garrod. This was not, as was suggested in cases of rheumatism, due to salicylates, for it was frequently found before salicylates were started. Dr. Garrod believes the frequent occurrence of this substance in the urine of choreic patients affords evidence that one at least of the perverted chemical processes which accompanies rheumatic attacks, is shared by chorea. It may ultimately be found that the presence or absence of this pigment affords a means more delicate than any which we yet possess of distinguishing which cases of chorea are due to the rheumatic taint, and which own some different causation.

The *termination* of chorea is comparable to the slow convalescence from an infective disease. Recovery is generally gradual, and occasionally the subsidence of the spasms in severe cases of chorea is not followed by any evident improvement in the patient's general condition; the patient may become perfectly quiet, and yet may remain for two or three weeks unable to stand, and with little power in the arms. After the attack the weakness may be so great as to be what is termed a post-choreic paralysis, a condition which, in a few weeks, passes away.

The *prognosis* is in most cases ultimately good, but one attack, as in rheumatism, malaria and pneumonia, predisposes to another. Recurrence is common and may occur only a few weeks after recovery or not for months or years. This proneness to recurrence seems to have no dependence on any preceding rheumatism, and when it recurs the movements do not necessarily start in the same manner or on the same side as the previous attack; in fact, for a successive number of attacks to start on the same side is very rare, indicating that the retrograde or degenerative change of the nerve cells is completely recoverable and that it is due to some agent ever ready in these patients to lead to a change in that part of the brain whose resisting power has become weakened. This liability of chorea to recur was noticed by Sydenham,[2] who states that "as the disease is liable to return again, I think it well for the patient to be purged about the same time, or a little earlier, the following year."

The mortality from chorea and from acute rheumatism *per se* is found, curiously enough, to be identical, the figures being 2 per cent.[43] of all cases.

The *treatment*, it is urged, affords strong evidence that chorea is not due to the same infective agent as that causing articular rheumatism, as it is unaffected by the administration of salicylates; but then salicylates do not cure acute rheumatism they only lesson the symptoms. One may compare the result of the administration of salicylates in articular rheumatism and chorea with the result of giving mercury and potassium iodide in syphilis and general paralysis of the insane or locomotor ataxy. Leredde[44] states that he has cured a case of tabes dorsalis by the administration of heroic doses of mercury.

A much wider conception is now entertained of the various manifestations of rheumatism, and one recognises as rheumatic besides an arthritis a form of tonsilitis, pharyngitis, iritis, varieties of erythema, urticuria, purpura, periosteal nodes, integumentary nodules, endocarditis, myocarditis, pericarditis, pleurisy, orchitis, and no less the rheumatic nature of vague pains commonly called "growing-pains" in children, and one may add to this list chorea minor, which Sir Andrew Clarke named "Rheumatism of the Brain." Whether all these manifestations are due to one and the same infective agent remains to be proved; but it can safely be said that, from a study of the bacteriology and clinical facts they are all due to a closely allied agent. *The hypothesis which therefore seems best to explain the facts of chorea minor as herein put forward is that the disease is due to an infective agent, closely allied to, perhaps identical with, that which causes acute articular rheumatism.*

41 Lancet, 1892, vol. i., p. 793.

42 British Medical Journal, 1883, vol. ii., p. 1060.

43 Report of Collective Investigation Committee of the British Medical Association. Enquiry No. II., prepared by Mackenzie. British Medical Journal, 1887, vol. i., p. 430.

44 Medical Record, January 17th, 1903.

Passim.

Arrangements in the theatrical world are proverbially uncertain, and dates of production never settled till quite late, so that we take this opportunity of calling attention to the fact that the production of "Flodden Field" and a One Act Comedy by Mr. Beerbohm Tree, at His Majesty's, on behalf of Luke Ward, Guy's Hospital, will positively take place on MONDAY, JUNE 8th, a date we hope all our readers will bear in mind as the notice is short and the chance one not to be missed.

The magnificent nature of the gift is shown by the fact that the total receipts will be handed over without the slightest deduction for expenses, an item that before now has all but annihilated the profits, and this is the more munificent when it is borne in mind that the pieces presented are both new, and consequently the entire outlay and expense of mounting and dressing two new plays has to be borne.

It will be a peculiarly attractive evening for all who follow the fortunes of Guy's and make a point of attending our functions. Not only is there an unwonted attraction of a first night performance at one of the most famous theatres in the world, but there is also the peculiar interest that the Poet Laureate is making an excursion into the dramatic verse on one of the most famous and celebrated of the old time border battles, fought nearly four hundred years ago. It should be a memorable evening, and we think the fortunate playgoers will enjoy an unusually interesting and pleasant evening.

After the many points of interest it may seem a little of an anti-climax to refer to the appearance of Mr. Tree in a One-Act Comedy after the more serious (we suppose) heroic epic, or to dwell on the fact that the performance will take place under the direct patronage of H.R.H. The Prince of Wales, our indefatigable President.

It is rumoured, we fear without truth, that possibly the One-Act Comedy will be an adaptation of a well-known story by the one and only Rudyard Kipling, which, if true, would by its sharp antithesis, add great interest to the performance of "Flodden Field."

The point about the performance is that it is devoted to a special and most praiseworthy object—the renovation and restoration of Luke Ward. Just as Job was renovated at the sole cost and charges of Mrs. Farquhar and her son as a memorial of her husband, so Luke is to be restored by the company of His Majesty's Theatre and a bed endowed in perpetuity in memory of that fact. These two wards were badly in want of renovation, but otherwise would not have been done from want of funds, and there is no doubt they both badly need it. The following is the programme:—

"FLODDEN FIELD"

A Drama in a Prelude and Three Acts by The Poet Laureate.

James IV. (King of Scotland) ... ... Mr. Tree.
The Earl of Surrey (Commander of the English Forces) ... ... Mr. Oscar Asche.
Sir John Heron (Owner of Ford Castle) ... . Mr. J. Fisher White.
Seneschal of the Castle ... Mr. Lionel Brough.
Donald Grey (Captain of the Ford Troop) ... ... Mr. Henry Ainley.
(By kind sanction of Mr. George Alexander)
Margery (an Orphan adopted by Lady Heron) ... . . Miss Miriam Clements.
An Apparition ... ... Miss Helen Ferrars.
Lady Heron (Wife of Sir John) Miss Constance Collier.

Servitors, Attendants, Gentlemen-at-Arms, English and Scotch Soldiers.

Prelude ... ... Scene—The Exterior of Linlithgow Castle.
Acts I., II. and III Scene—Interior of Ford Castle.
Time ... September 9th, 1513.

Mr. Percy Pitt has composed the music to "Surrey's Battle-Song," and Mr. Coleridge-Taylor that for "Love is a Dream." Mr. Percy Anderson has designed and supervised the Costumes for the play. All these three Gentlemen have generously given their services on this occasion, as well as the Artistes performing in the play.

"Flodden Field" will be followed by a One-Act Comedy, in which Mr. Tree will sustain the principal part.

Prices: Stalls, £3 3s.; Balcony Stalls, £2 2s. and £1 1s.; Balcony, 15s.; Upper Circle, 10s. 6d., 7s. 6d. and 5s.

Vouchers may be obtained from Henry Williams, The Counting House, Guy's Hospital, to whom all remittances should be sent.

The weather has so interfered with cricket that it is difficult to estimate our prospects. The M.C.C. match was abandoned, Beckenham was a draw, and we have lost to London County and defeated the Blue Mantles. The hot weather will probably make our cricket position more definite, and probably we shall find that our deficiencies lie in fielding (catching particularly) and in bowling, but we have every hope that a strong attempt will be made to regain the Cup.

On behalf of the Haven—to give it its full title, The Guy's Hospital Children's Home—at 182, Devonshire Road, Honor Oak Park, a Sale of Work and a Garden Fête will be held in the grounds of the Nurses' Recreation Society, Dunoon Road, Forest Hill, on Saturday, June 27th, 1903, from 3 p.m. to 10 p.m. We append a list of stall-holders and the price of admission. There will be variety entertainments at the capable hands of Mr. Woodward, coker-nut shies in the hands of Mr. "Peter" Jackson, and Mr. Horace Cutler, a fine art gallery, a shooting gallery, and numerous other attractions, including music by the Ladies' Amateur Harp, Mandoline and Guitar Band, directed by Mrs. Perkins, and the band of the "M" Division of the Metropolitan Police. Illuminations in the evening, but we deeply regret to hear that dancing on the green has been eliminated, perhaps it is not too late yet to hear of its restoration. We are sure a *Maypole* and Punch and Judy would also be additions, but we are confident that even in the absence of the latter the many friends of the Institution will rally round the Fête, and we are sure that the nurses and students will be largely represented:—

General Stalls—

Mrs. H. Cosmo Bonsor, the Matron and Nurses of the Hospital.

The Countess of Bective, Lady Henry Bentinck, Mrs. Eason, Mrs. Higson, Mrs. Wells and Forest Hill Ladies.

The Hon. Mrs. Talbot, Miss Gardiner, Mrs. Fagge and Ladies of Guy's Staff.

Mrs. Kirby. Miss Grossmith, Mrs. Parry and Shortland Ladies.

Flower Stall—

Mrs. M. Trevelyan Martin and Mrs. Herbert Raphael.

Refreshment Stall—

Mrs. R. A. Hankey and Mrs. E. Cooper Perry.

Irish Dairy Stall—

Miss Cary Jephson and the Misses Cornielle.

Admission 1/- Children under 12, half-price.

The advent of Spring has turned thoughts to the great boon of the swimming bath in the Nurses' Home, and the number of early bathers and late bathers has greatly increased. We should like to remind all who bathe that boots should be removed before entering the actual bath-room, as they carry in cinders from the path outside, which thence either gravitate into the bath (matter quite out of place) or else adhere in a most unpleasant manner to the soles of the bathers, an arrangement which has caused considerable irritation both local and general. It is a small matter but easily remedied by a little care and forethought—*verb. sap.*

In the Nursing part of the Hospital for some time past Miss Esther Young has been contributing Advice to Nurses, which is now published in a pamphlet (1s.). There are few things more difficult than to write in cold dispassionate sentences advice to others which must consist of "don'ts," and to convey thoughts of higher motives and of religious feeling without carrying the most hateful suspicion of cant and preaching, and yet there was not a really adequate publication on such an important subject that combined sound advice with practical value. The printed collection of pages on this subject by Miss Esther Young forms in this respect a most invaluable and meritorious exception. Alone among a mass of writing, it contains sound commonsense with a truly admirable underlying practical Christianity. While avoiding humbug and high-falutin, but deeply imbued with high ideals, we have no hesitation in saying that every nurse will do well to read her pamphlet and to ponder its teaching. We were not enamoured of its form as it appeared in series, and consider some of the illustrations rather insulting to the nurse's intelligence, but collected, the pages form the best Advice to Nurses we have ever come across, even in the sea of Introductory Addresses and Nursing Guides.

We should like to repeat that we are always anxious to publish any details of interest to their contemporaries, such as marriages, appointments, and so forth, of any nurse, sister or student, and particularly of those who have left the hospital, as it often is the only means of letting their contemporaries know their whereabouts and their doings, and we hope our readers will send prompt intimation of such changes on a post-card to the editor.

We should be very glad to receive any more copies of the *Guyoscope*, bound or unbound, for the purpose of presenting a complete set to the Guy's Library, which does not possess any copies at all. Please address them care of the Editor, who will do his best to get a complete set bound for presentation in their covers, if possible.

Some of the flotsam that arrives in the Editor's box is often amusing, but among absurd publications must be numbered the "Journal of Health and Beauty." The cover is a representation of beautiful and robust maidens wearing tight-laced corsets and short skirts dancing round a Maypole. Inside, passing the allurements of "Planchette for those who like the supernatural," or a "real downright good evening," and an advertisement of £1,000 in prizes (to which the editor ingenuously adds, "This competition does not require any high order of intellectual ability,") we come to the "Gem" advertisements, and then to the chief article, embellished by a photograph in which ordinary muscles by careful focussing are made to appear well developed, though a naïve note adds that if Mr. Inch had tried to force his development beyond the point portrayed he would probably have injured his health, a purely groundless fear, as if he had taken a worse photograph he could have further increased the apparent development without greater difficulty, and his actual development was never near this dangerous state. But the gem of the collection is "How to treat Cancer," by a London physician (who, it is true, treat many cancers, but in general, unwittingly). High frequency currents are advocated, with forty grains of calcium sulphide, and dietary, and there are two well-authenticated, inoperable cases, in which this remedy caused the disease to disappear. What restraint!!! he might, on the one hand, have called it two hundred, or, on the other, dilated on the momentous nature of this cure, so long and so ardently desired. But no; the talented but anonymous author only reports that he has attempted to carry out the treatment on a small scale in general practice, and the results so far have been very encouraging. Two cures of an incurable disease merely encouraging. What modesty and reticence!!!

From this one passes without difficulty to Captain Thomas McCullum's treatment of Constipation by wet cold compresses of distilled water and a pint and half of warm water as an enema (the latter part being, we opine, the active principle), and finally a letter announcing the discovery that vaccination is a filthy operation, scientifically foolish. The paper throughout is crammed with unpleasant advertisements and dangerous falsehoods. The article on cancer is one of those articles that lead the ignorant public (and only the very ignorant could read such a paper) to attempt quack remedies till too late for surgical treatment. Its very existence as a paper is phenomenal, the fact that it was sent for review shows its assurance to be astonishing, but its publication by a well-known firm seems to us deplorable.

The nomenclature of the wards dates we suppose from the establishment of the Hospital, but necessarily is liable to alteration. In whose hands the origination of the naming lies we know not, whether it be the Treasurer, the Governors, House Committee, Staff and School Committee, or even if this is a detail that concerns the Superintendent, Dean or Matron, but whomever it may concern we hope the right of Addison to a name in the new system in Hunt's House will be carefully considered. Philip is a name we care not for, his virtues and his title to consideration have not half the claim on us that our Addison has, and the latter is a name that ousted recently from Queen will we hope be perpetuated over the portal of the present Mary

ward. At all events, whoever the authority is, we appeal on behalf of what we know to be the general feeling in the matter.

HARDLY was the ink dry on the gibe we aimed at the South African memorial than workmen arrived bearing a mighty slab of marble, and having erected a green sail-cover screen retired to meditate. The last week, however, the curious have seen a large proportion of the memorial placed in situ, the marble being of a yellow hue, and it really seems as though in the near or even immediate future the memorial will be completed.

A somewhat novel appearance has been given to the approach to Clinical by the erection and planting of two rockeries at the parting of the ways to John and Miriam. We know not to whose taste we should attribute the same, but the effect is undeniably pleasing.

FORTUNE is the butt of gamblers and is often accused of wanton frivolity in the bestowal of her favors, but none will quarrel with the turn of the wheel which sent Mr. Robert Gordon into Job about a fortnight ago. Sister Job, on her return from the war, was appointed to Job in its unrestored condition. Since then the generosity of Mrs. Farquhar has transformed Job into the most up-to-date ward, and now Mr. Gordon, hearing casually on an official visit that there was no balcony, quietly laid down £1,000 for the necessary alteration, and expressed his intention of seeing the work put in hand at once. Our heartiest thanks for so generous a gift that will be tremendously appreciated.

SWEET are the uses of advertisement. To the innumerable pills, capsules, tabloids, has succeeded a most palatable form, namely, a large box of Oatmeal Stout from Messrs. Duncan and Gilmour. By an unusual chance the box arrived at the Hospital unobserved, and as it had not been reported at the GAZETTE Office, Messrs. Gilmour kindly sent another sample which has been duly tasted by all who are competent to judge, and highly approved of. The analyst's report is not to hand, but the use of this old English beverage is not likely to suffer from his report, we should imagine, and indeed if people will drink such beverages, a practice we neither recommend nor condemn, such well-known and reliable beer and stout as this with meals is not a prescription that most doctors will quarrel with.

THERE arrived late last Autumn a specimen of Messrs. Cadbury's well-known chocolate. The specimen arrived, and the handy-man who tastes and experiments was summoned by the manager for his report on the same, and though it was but a few days later nothing was discovered but empty boxes and extreme cheerfulness on the part of the GAZETTE Committee, so we presume that the sample gave satisfaction, but analysis or personal commendation we cannot give.

Two very neat valentines are well worth reproducing from the *St. George's Gazette*, the art of which is sufficiently apparent to outsiders to appeal to them—

To the Pink Paper Brigade—

> Myself when young did eagerly frequent
> Doctor and Saint, and heard great argument,
> About it and about. But evermore,
> Came out by the same door wherein I went.
> —*Omar.*

To St. Bartholomew's Hospital—

> Not only what my revenue yielded,
> But what my power might else exact.
> —*The Tempest.*

To Out-Patient—

> Strangely visited people, all swollen and ulcerous,
> Pitiful to the eye. —*Macbeth.*

To a Female Drunk—

> So was hir joly whistal wel y—wet.—*Chaucer.*

IT is always interesting to read the magazines and gazettes of our nearest rivals, and those who read them in the Library cannot fail to have been struck with the unanimity with which most hospitals have been grumbling about their hat and coat arrangements. With us the difficulty is still greater, the exact number of

men who pour into the hospital we know not, but it is between three and four hundred a day, we believe, and but a small percentage of those cloak in the cloak room. Every available partion of the Library and Club is crowded wtth hats and coats to the inevitable confusion and loss at times, but, on the whole, we are at least free from that difficulty, but there have been sharp remarks about the arrangements elsewhere.

Some mornings back the travellers by the medical stairs were startled by the distinct and uncomfortable impression of falling water, and on enquiry we were cheerily informed that the 25,000 gallon tank had sprung a leak, and might at any moment sweep down the stairs on the unfortunate wights who might be passing. Equally encouraging was the comfort that it was impossible to stem the leak or to forecast its development. However, nothing has happened except that signs of a new tank have developed outside the Dean's office, to be erected at a still greater height.

We have much pleasure in printing the Essay that took the Treasurer's Prize at the last meet- of the Physical Society, particularly because it was won by a former Dental House-Surgeon, who had already gained a similar prize at the Dental Society. Curiously enough the Manchester students have seen a chief prize there in medicine carried off by a Dental student.

Change of Address.

J. N. Gardiner, Plague Medical Officer, Punjab Club, Lahore, India.

Southwark Infirmary, East Dulwich Grove.—Miss Elizabeth Gow Graham has been appointed Sister. She was trained at Guy's Hospital, London, and has been Nurse at the Hospital for Children, Mrytle Street, Liverpool, and Charge Nurse at the West Norfolk and Lynn Hospital. She holds the L.O.S. certificate.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Past v. Present Tennis Match.

The Eastern Hospital,
Homerton, N.E.

Dear Sir,—I have promised to get up the Past team for the Past v. Present lawn tennis match on June 20th. Would you mind having a notice inserted in the next number of the Guy's Gazette, asking any old Guy's man who desires to play to send in his name as soon as convenient to me at the above addres.s—Yours truly,

May 17th, 1903. E. W. GOODALL.

Nursing News.

Matron's Office.

On May 2nd, Sister Lazurus, Miss Arnold, left the hospital to take a long holiday after over six years' service. Miss Katherine Powlett, Surgical Night Sister, has been transferred to Lazarus ward, and Mrs. Strathern has returned to take up the duties of Night Sister pro tem.

Miss Kate Neale, who completed her three years' training in March, has been appointed Probationary Sister, and took up her duties as temporary Housekeeper on May 4th.

On April 21st, Nurse Layton left the hospital, and Probationer Lokier was appointed to succeed her as Head Nurse in Charity ward.

On May 2nd, Nurse Chittock left the hospital on completion of her three years' training, and Probationer J. Thomas was appointed to succeed her as Head Nurse in Dorcas ward.

On May 5th, Nurse Dingwall left the hospital on completion of her three years' training to take up her duties on the Private Nursing Staff, and Probationer F. Scott was appointed to succeed her as Head Nurse in Martha ward.

On May 13th, Nurse A. Rogers, Head Nurse in Queen, left the hospital on completion of her three years' training. Nurse Purse was transferred to Queen ward, and Probationer Crampton was appointed to succeed her as Head Nurse in Out-patient Department.

On May 20th, Nurse A. Wood, Head Nurse in Martha ward, left the hospital on completion of her three years' training.

Probationer Gilbert has been appointed Head Nurse in the Eye wards.

Pass List.

University of Cambridge, April, 1903.

DEGREE OF DOCTOR OF MEDICINE.

J. G. Taylor.

DEGREE OF BACHELOR OF MEDICINE AND BACHELOR OF SURGERY.

M. C. Hayward.

EXAMINATION FOR THE MEDICAL AND SURGICAL DEGREES, EASTER TERM, 1903.

PART II.—H. Ackroyd, A. R. Brailey, W. H. Brailey, H. A. Cutler, F. B. Manser, F. Richmond, R. D. Smedley.

University of Durham, April, 1903.

DEGREE OF DOCTOR IN MEDICINE.

H. C. Sturdy.

DEGREE OF BACHELOR IN MEDICINE AND BACHELOR IN SURGERY.

B. Glendining. A. A. Miller.

Final Conjoint Examination, April, 1903.

MEDICINE, SURGERY AND MIDWIFERY.—*H. Watts.

MEDICINE AND SURGERY.—*C. H. Dawe, R. Larkin, E. H. B. Milsom.

MEDICINE AND MIDWIFERY.—J. M. Bickerton, P. R. Bolus, C. E. Iredell, C. H. Reinhold, H. D. Smart.

SURGERY AND MIDWIFERY.—*G. L. Buckeridge, J. Goss, *H. C. C. Mann, C. M. Murray.

MEDICINE.—C. E. Bartlett, P. C. V. Bent, H. W. Bethell, *J. D. Bridger, *J. F. Douse, J. H. Donnell, *E. G. Goldie, *G. Moir, *J. D. Pearson, *E. Roberts, *F. C. Robinson, E. W. Strange, *B. H. Wedd.

SURGERY.—J. S. Cooper, *H. M. Goldstein, T. C. Lucas, A. P. Piggot, *B. I. Rahim, *W. W. Read, T. H. F. Roberts, *C. R. Shattock, R. Willan, *H. C. Winckworth.

MIDWIFERY.—C. M. L. Cowper, C. H. Denyer, F. G. Goble, E. N. Jupp, R. Moyle, G. Nunn, F. H. Parker, M. Bramley Taylor, F. H. Wallace, E. L. Ward, A. R. Wilson, H. M. M. Woodward.

*Denotes completion of examination.

Licence in Dental Surgery, May, 1903.

SECOND PROFESSIONAL EXAMINATION.

PARTS I. AND II.—H. P. Aubrey, A. R. Beaumont, J. S. Brown, F. Chilton, G. L. Dymott, H. W. Gwyther, H. P. Hooper, A. L. Mason, F. W. Parfitt, S. W. Robinson, A. O. Trotter, T. Vernon, R. Wallis, E. L. Weaver.

PART I. ONLY.—*A. D. Crofts, W. H. Elwood, *H. J. Fox, *F. W. Goodwin, *R. G. Harrington, A. E. Holman, *R. W. Jones, *H. W. Jones, F. H. Lennox-Jones, H. C. Malleson, *A. L. Mathews, S. H. Peatfield, A. E. D. Prideaux, R. A. Scott, *J. Stevens, *E. O. Stevens.

PART II. ONLY.—H. E. Collett, W. E. A. Derriman, A. H. Forbes, W. J. Goodman, C. J. S. Kliszczewski, C. L. Palmer, A. E. Preston, L. U. Ransford, *H. W. Wallis, E. White.

*Denotes completion of examination.

FIRST PROFESSIONAL EXAMINATION.

MECHANICAL DENTISTRY AND DENTAL METALLURGY.—F. L. Aubrey, W. J. Bollard, †W. E. Cook, T. B. R. Ellis, W. Elwood, A. Alan Forty, F. H. Fuller, F. J. Goodman, A. Hammond-Smith, W. A. Helyar, P. H. Hickman, F. A. Husbands, P. E. Luce, J. W. Mawer, N. McL. Nibbs, H. A. Pallant, H. M. Peacock, H. G. Pearce, E. L. Pilbeam, H. Poyton, H. J. Russell, J. F. Ryder, *H. J. Snowden, J. H. Williams, W. J. Wormald.

*Mechanical Dentistry only.

†Dental Metallurgy only.

Guy's Hospital Chapel (Students') Choir

SOME vacancies in the above have still to be filled up. The Hon. Secretary invites applications, more particularly from freshmen. As far as can be ascertained, this Institution, together with its contemporary and supporter, the Students' Glee Club, is unique in the history of, at least, the London Hospitals, and the excellent condition of both speaks well for the goodwill of Guy's.

As the Choir is still in its youth, it would be as well to give a summary of its conditions:—

1. Members are to attend Morning and Evening Service on one Sunday in each month, as prearranged.
2. If unable to attend, they shall communicate with the Hon. Secretary and obtain a substitute.
3. Members are welcome to attend *any Sunday* they please, but such attendances are not to interfere with their special prearranged Sunday.

Present members are specially reminded of this last condition.

Supplemental information to the above can readily be obtained from the Choirmaster, Mr. Taylor, the Hon. Secretary, or any member of the Committee.

R. FELTON, Hon. Secretary.

Notice.

ASSISTANT DEMONSTRATOR OF ANATOMY, MAY, JUNE AND JULY.—Mr. G. F. E. Allison.

Reviews.

The price of books submitted for review should in every case be stated.

Physics and Chemistry. By Cortin and Stewart. (Messrs. J. & A. Churchill.) Price 6s. 6d.

This small but complete work is designed for the use of men preparing for Part I. of the College examinations and it seems to us to admirably fulfil its purpose. If at all it is too elementary and clings too closely to the syllabus, but as a compendium of what is actually necessary it is very useful, though all medical men ought to learn more than is contained within its pages.

First Aid to the Injured and Sick. (Warwick & Tunstall). Third Edition, 1903. Price 2s. 6d.

As an elementary and handy guide to that section of the public which delights in a little medical knowledge, this volume is as good and safe a guide as we know. It has some more excellent diagrams, and its information is, as far as we have seen, accurate and correct. No one would be the worse for knowing all that is in it, and we can recommend the perusal of it to all who wish to learn. The bandaging teaching is excellent.

Diseases of the Skin, their description, pathology, diagnosis and treatment.—A. Radcliffe-Crocker, F.R.C.P. (H. K. Lewis, London.) Two vols, four plates, and 112 illustrations. Price 32s. net.

These two volumes form a complete exposition of the present state of knowledge with regard to diseases of the skin. They represent the deductions, and careful deductions, from a large experience, and on that account they are highly valued, so much so that further editions were required. The number of new articles and the alteration in the old sufficiently denote the increased knowledge of skin affections. The novelties include articles on X-ray, Dermatitis, Serum Eruptions, Diatetic Bronzing, Veldt Sore (familiarised by the South African War, and occurring twice as often in the Cavalry as in the Infantry), Ulerythema Ophryogenes and many others.

The articles are well written in a clear terse and simple style, and the volumes form a valuable reference book for consultation about any rare or unusual skin affection. Reference is made to the necessity of having an atlas, but still more is it necessary to see some skin practice to be able to appreciate this most excellent work.

Criticisms in detail are almost impossible in such a work, and treatment is still to a large extent empirical and based on experience rather than on actual tangible indications, a fact that makes skin lesions more interesting to the expert than to the general practitioner. Those who have the time and energy to devote to the study will find the book will repay the labour, though on some points his views are personal to himself and not in agreement with other experts. Perhaps to the less ambitious such things as syphilides, erythema nodosum, scarlatiniform eruptions, and so forth, will suffice for reference, while the great mass of rare and intractable diseases may be skipped. But difficult as the diagnosis of skin eruptions often is there is no doubt that the book gives several useful points to save errors in the all important differential diagnosis of exanthemata.

Diseases of Women: A Clinical Guide to their Diagnosis and Treatment. By George Ernest Herman, F.R.C.P. 884 pages, 250 illustrations. (Cassell & Co., Ltd.). Price 25s.

This well-known work has passed through three editions and remains one of the standard works.

The author's style and teaching are peculiarly his own, but he possesses, as he claims, the only true authority for writing a book, and that is clinical experience. His book is full of observation, wise doubt, reflection, and fair statement. It is thoroughly solid and sensible. We believe it to be the best work on the subject and heartily recommend it.

Having thus expressed our candid opinion of its deserts, we are at liberty to criticise what seems to us mere imperfections. We believe it is well to compress all abdominal sections overnight and to get the pubes shaved by a competent nurse beforehand.

He recommends silk for the abdominal wall saying the material is of slight importance. We believe it essential to use salmon gut for through and through sutures, which will avoid the necessity of removing them till the tenth day. Painful stitches will be saved, which, with salmon gut and a superficial horsehair suture, are very rare and sinuses quite uncommon, but with silk left six days suppuration is common.

It is an excellent work, and we can recommend it, especially the first nine chapters, in which there is much that can be found nowhere else. We think the price unduly high.

Papers by Guy's Men.

Acute Amaurosis following Infantile Convulsions. By Henry Ashby, M.D., F.R.C.P. Lond.—*Lancet*, 9th May.

Some Observations on the Blood Gases in Diabetes. By A. P. Beddard, M.A., M.D., F.R.C.P.; M. S. Pembrey, M.A., M.D.; and E. Ivens Spriggs, M.D.—*Lancet*, 16th May.

Where Memory Sleeps. An Address delivered to the South Essex Section of the Metropolitan Counties Branch of British Medical Association.—*Lancet*, 9th May.

Some Remarks on the Co-existence of Skin Diseases. By G. Norman Meachen, M.D., B.S., M.R.C.P. Lond., M.R.C.P. Edin.—*Medical Times and Hospital Gazette*, 25th April.

Novelties.

ANTIPHLOGISTINE.

Antiphlogistine is a glutinous compound which is reputed to be antiseptic, to have great powers of retaining heat, and also to be hygroscopic. Its most obvious use is as a substitute for the more old-fashioned linseed poultice, which has fallen into undeserved disrepute of late years. It certainly answers well, though we are very sceptical about its efficacy in such cases as dysmenorrhœa, eczema and consumption. Almost every drug that emanates from America is reputed to cure dysmenorrhœa, so easily in fact that we should have thought there was no opening for any new treatment as there is in England, where its cure is extremely difficult in many cases. It is a warm, sticky preparation, and while we are not enthusiastic about it, it certainly fulfils the claims of its makers—"harmless, soft and pliable, non-irritating, non-toxic, soothing and antiseptic poultice and surgical dressing, always ready for immediate use, possessing hygroscopic, nutrient, exosmotic, endosmotic (we cannot guarantee the last three), and indirectly anodyne and hypnotic properties." It is supplied by the Denver Chemical Company, New York. Many use this preparation in America, and are enthusiastic about its merits.

Appointments.

CIVIL.

Biddle, H. G., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer of Health for Broadstairs.

Hills, W. E., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer to the Hampstead Division of the London Postal Service, *vice* C. N. Cobbett, M.D. Edin., resigned.

Lower, N. G., L.R.C.P. Lond., M.R.C.S., has been appointed Certifying Factory Surgeon for the Presteign District of the County of Radnor.

Wacher, Sidney, F.R.C.S. Eng., has been appointed Certifying Surgeon under the Factory Act, for the Canterbury District of the County of Kent.

Worts, Dale G., L.D.S. F P.S. Glasgow, has been appointed Honorary Dental Surgeon to the Essex and Colchester Hospital.

NAVAL.

Skinner, E. W., M.D., has been appointed Surgeon and Agent at Rye Harbour and Camber.

Papers by Guy's Men.

The Effects of Intravascular Injections of Animal Tissues. By Swale Vincent, M.B. Lond., L.R.C.P. Lond., M.R.C.S., and William Sheen, M.D., M.S. Lond., F.R.C.S.—*Journal of Physiology*, April 28th.

Sport.

Cricket.

GUY'S v. BECKENHAM.

This, the first match of the season, was played on Saturday, May 9th, at Beckenham, on a dead, but easy wicket, and resulted in a draw, the scores being, Guy's 221; Beckenham 66 for four wickets.

Guy's batted first, and thanks to excellent innings' by Langdale, Morgan and O'Brien, put together the respectable total of 221. The latter should prove a decided acquisition to the team, his play all round being excellent, and especially strong on the leg side. Langdale and Morgan both played well and freely, hitting well and often, the former had hard luck in not reaching his century. Davies and Foster bowled well, the former having hard luck on several occasions, his ball only just missing the stumps. After four of our opponents' wickets had fallen, rain stopped any further play.

Guy's.

F. Morres, c Curwen, b Cooper	18
R. Willan, Jun., b Cooper	8
F. Husbands, b H. Z. Baker	0
A. B. O'Brien, c & b Cooper	31
H. M. Langdale, lbw, b Vincent	88
M. McPherson, c F. D. Browne, b P. C. Baker	1
E. A. Collins, c & b Cooper	0
E. Morgan, b Craig	57
A. L. Foster, not out	5
J. F. Young, b Craig	0
L. G. Davies, c H. Z. Baker, b Craig	2
Extras	11
Total	221

Beckenham.

C. O. Cooper, c McPherson, b Foster	23
J. D. Craig, c Willan, b Foster	25
J. K. Stenning, b Davies	8
G. J. Gulliver, lbw, b Foster	2
F. D. Browne, not out	3
P. C. Baker, not out	0
Extras	8
Total (4 wickets)	66

H. Z. Baker, W. M. Torrens, A. Brown, J. E. Curwen, H. B. Vincent, did not bat.

Bowling Analysis.

	Overs.	Maidens.	Runs.	Wkts.	Average.
L. G. Davies	13	6	11	1	11
A. B. O'Brien	5	0	29	0	—
A. L. Foster	8	1	18	3	6

GUY'S v. LONDON COUNTY C.C.

Played at Honor Oak on Wednesday, May 13th, and resulted in a substantial victory for our opponents.

The County had a powerful side out, including the distinguished veterans "W. G." and Murdoch. We won the toss, but fared badly against the bowling of Posthuma and Gamble, and only put together the moderate total of 102. We should have done better, as the wicket, though dead, was not difficult, and but for Davies hitting well at the end, our total would have been very small. W. L. Murdoch's century was a good effort, his hitting being hard and clean, and included 12 fours.

GUY'S.

F. Morres, c Gale, b C. Kenward	36
J. S. Bookless, b Gamble	1
R. Willan, Jun., c Posthuma, b Gamble	0
A. B. O'Brien, b Posthuma	5
H. M. Langdale, b Posthuma	2
E. Morgan, st Haywood, b Posthuma	0
M. McPherson, b Gamble	5
A. Leeming, run out	1
E. A. Collins, c Gale, b Gamble	5
J. F. Young, not out	8
L. G. Davies, b W. G. Grace	34
Extras	5
Total	102

LONDON COUNTY.

W. G. Grace, hit wicket	21
W. L. Murdoch, b Young	114
D. Reece, lbw, b Morgan	0
K. S. Singh, c Bookless, b Davies	30
R. Kenward, not out	35
P. G. Gale, not out	12
Extras	31
Total (4 wickets)	243

—. Posthuma, —. Haywood, C. Kenward, L. Corell, —. Gamble, did not bat.

GUY'S v. SURREY WANDERERS.

Played on Saturday, May 16th, at Honor Oak Park, and resulted in a draw, owing to rain stopping play. Guy's again won the toss, and put together 153, Husbands and Morgan being the chief scorers; the former playing a sound innings. The Wanderers lost 3 wickets for 33 runs, when rain stopped further play. Davies took 3 wickets for 9 runs.

GUY'S.

F. Morres, c Willan, Sen., b Colman	5
J. S. Bookless, c Hadath, b Barker	7
A. B. O'Brien, st Brooks, b Jephson	24
R. Willan, b Barker	11
H. M. Langdale, lbw, b Wells	15
F. Husbands, c Wells, b Barker	28
E. Morgan, b Barker	29
L. G. Davies, not out	16
M. McPherson, b Jephson	0
A. L. Foster, b Barker	12
E. A. Collins, b Barker	0
Extras	6
Total	153

THE WANDERERS.

S. Colman, b Davies	0
D. L. A. Jephson, lbw, b Davies	0
R. Brooks, b Davies	20
K. R. M. Barker, not out	6
Extras	7
Total (3 wickets)	33

L. S. Wells, R. H. Boulter, J. G. Hadath, K. Stafford Webber, T. Edey, E. L. Fischer, R. Willan, Sen., did not bat.

Guy's Hospital Lawn Tennis Club.

Owing to the bad weather the match v. Sidcup, on Saturday, May 9th was scratched.

On Saturday, May 16th, we beat Redhill, at Redhill, by 5 events to 2.

Lucas and Palmer lost to Waller and Layton, 10–12, 2–6; beat Bateman and Mordon, 6–2, 2–1. Jupp and Pinching lost to Waller and Layton, 0–6, 7–5, 0–6; beat Marten and Marshall, 6–4, 6–2; beat Batemen and Mordon, 6–2, 5–7, 6–0. Earle and Zorab beat Marten and Marshall, 6–1, 6–3; beat Bateman and Mordon, 7–5, 6–3.

Rain interfered greatly with this match and the rest of the events were abandoned.

On Wednesday, May 20th, we beat Blackheath A at Blackheath by 5 events to 3.

Lucas and Palmer beat Plumer and Ralf, 6–1, 5–7, 6–4; beat Longstaff and Wetherell, 7–5, 6–4; beat Anderson and Edwards, 4–6, 6–2, 6–2. Winckworth and Zorab beat Plumer and Ralf, 6–1, 3–6, 7–5; drew with Longstaff and Wetherell, 2–6, 6–6; beat Anderson and Edwards, 4–6, 6–3, 6–2. Earle and Pinching lost to Plumer and Ralf, 1–6, 3–6; lost to Longstaff and Wetherell, 1–6, 3–6; lost to Anderson and Edwards, 2–6, 3–6.

Of last year's team we have lost the services of E. N. Jupp, B. H. Wedd and H. C. Winkworth, while T. C. Lucas, F. W. M. Palmer and A. Zorab still remain.

Owing to the very inadequate grant of money made by the Clubs' Union we have been reluctantly compelled to give up playing a second six this year, although there are plenty of men anxious to play and some very good material to select from. This is much to be regretted after the excellent fight made by the second six in the Junior Inter-hospital Cup Ties last year, and it must be remembered that it is from the second six that recruits for the first team are drawn. It is to be hoped that the Clubs' Union Committee will see their way to increase the grant, so as to enable a second six to play.

Guy's Hospital Rifle Association.

G.H.R.A. v. OLD ALLEYNIAN R.C.

Runnemede Ranges, May 9th. 200 & 500 yards.

GUY'S.

R. Felton	63
R. E. French	54
L. L. C. Reynolds	50
D. Reynolds	49
E. P. Minnett	48
W. H. S. Burney	44
TOTAL	308

OLD ALLEYNIAN R.C.

H. Carpmael	61
— Hart	59
L. U. Ransford	58
— Rigby	53
— Adams	46
— Green	41
TOTAL	318

THE ARMITAGE CUP.

First Shoot, Runnemede, May 13th. 200, 500 & 600 yds.

GUY'S.

G. F. C. Robinson	94
R. C. French	92
R. Felton	86
J. S. Cooper	78
F. B. Lowe	68
L. U. Ransford	64
TOTAL	482
St. Bart.'s	461
St. Thomas's	441

G.H.R.A. v. DULWICH COLLEGE.

Runnemede Range, May 13th. 200 & 500 yards.

GUY'S.

G. C. F. Robinson	64
R. E. French	63
R. Felton	59
J. S. Cooper	58
L. U. Ransford	55
L. L. C. Reynolds	56
F. B. Lowe	54
D. Reynolds	45
TOTAL	454

DULWICH COLLEGE.

Cpl. Lattey	64
L.-Sgt. Archer	61
L.-Cpl. Haydon	59
Sgt. Humphreys	57
Sgt. French	56
Pte. Catchpole	53
L.-Sgt. Warne	51
Cpl. Mears	40
TOTAL	441

Charles Murchison Scholarship in Clinical Medicine.

The next examination for this Scholarship will be held in the University of Edinburgh, on Wednesday and Thursday, the 1st and 2nd July, 1903.

The Scholarship is open to any Student of Medicine who, during a period of not less than five, nor more than seven, years, has been a registered Medical Student in attendance at Classes or Hospitals, in Edinburgh or London, recognised by the Medical Faculty of the University of Edinburgh, or by the Royal College of Physicians of London, and whether holding a medical qualification or not.

The Scholarship is of the value of Twenty Guineas, and is tenable for one year.

The examination will be conducted both orally and in writing, and the following arrangements will be adopted:—

Wednesday, 1st July.—10 a.m. to 1 p.m., Written examination in the Court Room, University; the questions to embrace Pathology and Therepeutics. 4.30 p.m., examination on Specimens.

Thursday, 2nd July.—12 to 2 p.m., Examination of patients in the Royal Infirmary. 2 to 4 p.m., Writing of Commentaries on the cases of the patients.

Intending candidates are required to send in their names, with evidence of their qualification to compete, to the Dean of the Faculty of Medicine, University New Buildings, Edinburgh, not later than the 27th of June.

(The examination for 1904 will be held in the Royal College of Physicians of London.)

A. R. SIMPSON,
Dean of the Faculty of Medicine.

University of Edinburgh,
May, 1903.

Deaths.

BIRKETT.—On May 8th, at Westbourne Rectory, Sussex, Edmond Lloyd Birkett, M.D. Camb., F.R.C.P. Lond., in his 90th year.

CROMBIE.—On April 29th, at 5, Golden Square, Aberdeen, Peter Crombie, L.D.S. Edin., aged 66.

ROPER.—On February 22nd. 1903, at Melbourne Arthur Leonard Roper, M.A., M.B., B.C. Camb., second son of Arthur Roper, M.D., of Colby, Lewisham Hill, S.E., aged 35.

ED.—J. M. B.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, SECRETARY'S OFFICE, GUY'S HOSPITAL.

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING AND SIXPENCE.

Calendar of Coming Events.

June, 1903.

Sat. 6.—Messrs. Golding Bird and Dunn's take-in; Drs., D. Isaacs and F. Rogerson; Cl., G. E. Malcolmson.
G.H.C.C., I., v. Hornsey, 11 a.m., home.
II., v. Merchant Taylors' School "A," 2 p.m., away.
III., v. Quernmore School "A," 2 p.m., Bromley.
G.H.L.T.C., I., v. Surbiton "A," home.

Mon. 8.—1.15 p.m., Clinical lecture by Dr. Horrocks.
Last day for applying to Registrar for Form of Entry for Intermediate M.B. Lond. Examination.
Mr. Tree's Performance of "Flodden Field" and "The Man Who Was," at His Majesty's Theatre, in aid of Guy's Hospital, at 8.45 p.m.

Tues. 9.—Exam. for Treasurer's Gold Medals begin.
July Appointment List closed.
Mr. Rowell's Demonstration on Anæsthetics, 12 noon.

Wed. 10.—1.30 p.m., Clinical lecture by Dr. Shaw.
G.H.C.C., I., v. Hampstead, 11 a.m., Hampstead.
II., v. City of London School, home.

Thur. 11.—Messrs. Jacobson and Fripp's take-in; Drs., F. W. M. Palmer and W. M. Mollison; Cl., B. Glendinning.
Application to Medical School Office for Schedules for the Second Conjoint Exam. to be made not later than this date.

Fri. 12.—1.15 p.m., Clinical lecture by Mr. Dunn.
Special Exam. for Dental Operative Prize, 9 a.m.

Sat. 13.—G.H.C.C., I., v. Wellingboro' Masters, 11 a.m., Wellingboro'.
II., v. Old Charlton, 2 p.m., home.
III., v. Boro' Road College "A," Isleworth.
G.H.L.T.C., I., v. Blackheath "A," home.

Mon. 15.—1.15 p.m., Clinical lecture by Mr. Fagge.
Cambridge 1st and 2nd M.B. Exams. begin.
July Dental Appointment List closed.

Tues. 16.—Application to Medical School Office for Schedules for Final Conjoint Exam. to be made not later than this date.
Mr. Rowell's Demonstration on Anæsthetics, 12 noon.

Wed. 17.—1.30 p.m., Clinical lecture by Dr. Shaw.
G.H.C.C., I., v. London County C.C., 11 a.m., Crystal Palace.
II., v. Norbury Park "A," 2.30 p.m., Norbury.
G.H.L.T.C., I., v. Connaught, Chingford.

Thur. 18.—Messrs. Symonds and Stewart's take-in; Drs., R. Franklin and E. W. Routley; Cl., H. Tipping.

Fri. 19.—1.15 p.m., Clinical lecture by Mr. Fripp.

Sat. 20.—G.H.C.C., I., v. Past, 11 a.m., home.
II., v. Blackheath "A," 2 p.m., Blackheath.
III., v. Home and Colonial, 2 p.m., away.
G.H.L.T.C., I., v. Past, home.

Guy's Hospital Gazette,

JUNE 6, 1903.

The Benefit Performance at His Majesty's Theatre.

IT will be with great pleasure and gratification that all will hear that the King has signified his intention of attending the forthcoming performance of "Flodden Field" and "The Man

Who Was," at His Majesty's Theatre, on Monday next.

By this gracious act His Majesty has shown his continued deep interest in our Hospital, for though as Patron of the King Edward's Fund for London which he initiated in 1897, when Prince of Wales. he can hardly identify himself with any individual charity, an exception could fortunately be made in the case of a special theatrical performance as the production of a play by the Poet Laureate. The King evidently anticipates the event with much interest, for in addition to the Royal Box he has ordered six stalls for his suite. Their Royal Highnesses, the Prince and Princess of Wales have also signified their intention of taking a second box, so that the presence of such a large number of the Royal Family will in itself make the occasion almost unique for any dramatic performance outside the opera. The other two chief boxes have been taken by the Countess of Warwick and the Poet Laureate respectively.

The performance itself will be exceptionally attractive.

The first production of a drama by the Poet Laureate in conjunction with a dramatised version of one of Mr. Kipling's most dramatic short stories, is a sufficient feast in itself, and when staged with all Mr. Beerbohm Tree's usual lavish equipment and artistically intelligent stage management, is sufficient to make the evening memorable from the dramatic standpoint alone.

The announcement that His Majesty the King will be present, has caused an enormous rush for seats by all that is most fashionable in Society, and by this time, in spite of the greatly enhanced prices, the whole house has been sold. Indeed, it is doubtful whether there will be any room for the general public to be admitted even to the gallery. We expect that Mr. Tree will be able to announce that the Hospital has benefited to the extent of not less than £2,000 as a result of the performance. Owing to the forethought and kindness of two most generous Guy's supporters, who desire to remain anonymous, the pit has been reserved for Guy's nurses and students. The seats in the pit will all be numbered and reserved and closed to the general public, so that every one holding a ticket will be able to pass into his seat at the last minute in comfort. Sisters and Nurses will attend in any part of the house in uniform if they so desire. The Students will wear evening dress except in the gallery.

The Poet Laureate's play will commence at 8.45 p.m., and last for one and a-half hours, after which there will be an interval of a quarter of an hour. Mr. Kipling's play, "The Man Who Was," will begin at 10.30, and last till 11.30.

It only remains for us to wish that all from Guy's who go to His Majesty's Theatre on Monday will, in every way possible express, on behalf of our Hospital, their deepest gratitude, both to the eminent actor-manager, who is responsible for the charity of the evening's performance, and especially to our former President, His Majesty the King, and His Royal Highness the Prince of Wales, our President at the present time, who with a kindness and tact pre-eminently their own have crowned the success of the evening with the promise of their presence.

It will be a source of especial pleasure to the Nursing Staff at Guy's if Her Majesty the Queen and Her Royal Highness the Princess of Wales, who have both shown their deep and personal interest in nursing matters, are also present on Monday evening.

Papers by Guy's Men.

Ateleiosis: A Form of Dwarfism. By Hastings Gilford, F.R.C.S.—*The Practitioner*, for June.

A Few Lessons from Fifty Cases of Operation for Carcinoma of the Tongue. By W. H. A. Jacobson, M.Ch. Oxon. (concluded).—*Ibi*

Some Retroperitoneal Cysts.

CLINICAL LECTURE BY MR. J. H. TARGETT,
Obstetric Surgeon to Guy's Hospital.

May 11th, 1903.

GENTLEMEN,—I have chosen this subject for consideration to-day because we have had recently three cases in Queen ward of cystic abdominal tumours, which were all diagnosed as ovarian cysts but were peculiar in their clinical characters. They were not strictly ovarian cysts; at all events two of them were not, and so the diagnosis was thus far wrong. I want to ask your attention particularly to the diagnosis, and if we have time we will deal with the pathology of retroperitoneal cysts afterwards.

CASE I.—MESENTERIC CYST.

History.—Mrs. N., æt. 65, multipara, admitted for abdominal tumour. Menopause twelve years ago. Five years ago patient had a severe illness, with stoppage of the bowels, abdominal pain and distension. Her case was regarded as hopeless but the obstruction was relieved without operation and she gradually recovered. Since that time she has had much trouble from constipation and often suffered from severe attacks of abdominal pain. Two months before admission her doctor discovered a swelling in the abdomen, which he thought was an ovarian cyst.

On admission.—There was a large rounded tumour in the centre of the abdomen, extending from about two inches above the umbilicus to just above the pubes, and rather further to the right than the left of the median line. The tumour was elastic, with an indistinct thrill, and very movable in all directions. Its right margin was much more definite than the left and by deep pressure its lower edge could be separated from the pelvis. The tumour could *not* be felt from the vagina and no impulse was conveyed from it to the cervix by abdominal palpation. There was resonance on both sides and above the tumour. No signs of ascites, no wasting, and no pain except when the bowels were obstructed—"stoppage of the food," as she described it.

Diagnosis.—The tumour was diagnosed as an ovarian cyst and its mobility was attributed to a long pedicle. The attacks of abdominal pain were regarded as due to partial twisting of the pedicle. As there were no signs of malignancy, operation was advised.

Operation.—On opening the abdomen a cyst was found in a nest of matted small intestines, with a large piece of omentum adherent to its upper surface. It contained about one and a half pints of thick chocolate fluid, with much cholesterin floating on the top. The omentum was ligatured and detached and after much trouble the adherent coils of bowel were separated. There was *no* pedicle, but the base of the cyst was implanted in the mesentery, near the lumbo-sacral angle of the spine. The cyst was carefully separated from its attachment, leaving a raw surface of considerable extent. This was closed over by drawing together the edges of the peritoneum with fine silk. The uterus and both ovaries were atrophied from age but otherwise healthy, and the cyst had no connection with the pelvic viscera. A good recovery ensued. The cyst was thin-walled, unilocular, and without septa or ingrowths upon its interior. It had evidently originated in the mesentery but there was nothing in its structure to indicate its exact nature. In the fluid contents there was much fat, granular matter and cholesterin.

I have indicated the main points of this case on the board:—

1. The tumour had the general characters of a cyst.
2. Its position was central.
3. It was separated from the pelvis and the loins. We could get our fingers down deeply below the tumour. That fact should always make you hesitate in the diagnosis of an ovarian cyst. The tumour did not go back into either loin, and we therefore thought it was not renal.
4. Another important point was its free mobility upwards and downwards, and from side to side.
5. It had no connection with the pelvic viscera. As a matter of fact we did not attempt to prove this point clinically; but the operation showed that it was so.
6. The history of chronic intestinal disturbance, the exact nature of which was not properly appreciated until after the operation.

The patient was in the habit of calling it "stoppage of her food"—not ordinary constipation. She said that some little time after meals, or on other occasions, she had a pain in a certain spot in the abdomen, at which the food seemed to lodge. It was apparently not a question of the lower bowel being distended, but a stoppage higher up. There had been several such attacks, with considerable pain and indigestion. But there was no wasting or other signs of malignancy. We now see the explanation of these symptoms. The operation showed that the tumour was a mesenteric cyst, developed in the mesentery of the small intestine near the lumbo-sacral angle, and having round it a veritable nest of small intestine and

omentum. It was partly covered by movable peritoneum at its base, but there was *no* pedicle. The operation consisted in detaching the adherent bowel and separating the peritoneal capsule from the base of the tumour, which was then enucleated. The raw surfaces were closed by uniting the edges of the peritoneal flaps with fine silk sutures. The tumour was a unilocular cyst, with dark brown fluid contents; and there was nothing in the structure of its wall from which we could learn its actual source.

Now let us consider why we were wrong in our diagnosis. I thought it was an ovarian cyst, with a twisted pedicle. Many of the clinical characters would have been the same on that supposition. The separation from the pelvis, as well as its great mobility, might have been due to a long pedicle. If this pedicle had become twisted on certain occasions and caused cramping pains, such symptoms might easily have been mistaken for intestinal trouble. But that was not a sufficient explanation, and there can be no doubt the patient had much more real intestinal obstruction than we imagined. If we had proved clinically that the tumour had *no* connection with the pelvic viscera, it would have been absurd to suggest an ovarian cyst. But she was an elderly woman, and we could not make out very much from vaginal examination, except that the uterus was not displaced, and that the lower end of the tumour could not be felt. There are two ways of excluding the pelvic origin of an abdominal tumour:—

(*a*) By giving an anæsthetic and making such a thorough bimanual examination as to feel both tubes and ovaries.

(*b*) By putting a tenaculum upon the cervix and drawing the uterus well down. Then notice whether you can feel any cord-like union between the uterus and the abdominal tumour. Such a cord would indicate an ovarian with a long pedicle. By one or other of these tests it would have been possible, I daresay, to have settled that this tumour had no connection with the pelvic viscera. I have seen these tests applied, and verified by operation, in more than one instance.

Our next case is of a very different type.

CASE II.—MESOMETRIC CYST.

History.—Mrs. A., æt. 53, multipara, admitted for prolapse and difficulty in micturition. Menopause occurred seven years ago. Has been troubled with prolapse for the last twelve months, and for four months has had pains in the back. A week ago she had a severe attack of abdominal pain and could not pass water; was relieved with a hot bath.

On admission.—An indefinite swelling can be felt in the abdomen which extends half-way up to the umbilicus. On bimanual examination a tense cystic tumour is felt which is so closely united to the uterus that abdominal pressure is directly communicated to the cervix. The uterus is much retroverted and prolapsed, and the tumour appears to be attached to the front of the body in the utero-vesical pouch, with bowel above and in front of it. There is prolapse of the vaginal walls, and the cervix comes down into the vulva on standing. Examination is difficult because of obesity.

Diagnosis.—The patient was sent to the hospital on account of the prolapse which could not be remedied with pessaries. The discovery of a tumour attached to the uterus explained the failure of the pessaries in supporting the prolapse. The tumour was thought to be a fibroid of the uterus attached to its anterior wall and mainly subserous. Its tense cystic feeling was attributed to mucoid degeneration after the menopause. The last pregnancy was twenty years previously, but there was no history of menorrhagia. The intimate union of the tumour with the uterus suggested fibroid rather than ovarian cyst. Operation was advised because of increasing difficulty with micturition and the probability that the tumour would continue to enlarge.

Operation.—On opening the abdomen and pushing back the bowels a dark blue cystic tumour was found in the right broad ligament. The right Fallopian tube was running across it near the top, and the round ligament coursed downwards and outwards in front of it. Posteriorly the right ovary was found quite separate from the cyst. The lower part of the cyst extended deeply into the right broad ligament and was in close apposition with the right side and front of the body of the uterus. After tapping the cyst, the anterior and posterior layers of the broad ligament were stripped back and the cyst-wall was easily shelled out of the cellular tissues. There was no proper pedicle, so the empty cyst was pulled up strongly and a ligature applied as low down as possible. The edges of the broad ligament were then sutured together over this stump. The patient recovered. The cyst was unilocular, the size of a large cocoa nut, and it seemed to have been wholly removed. It had a thin white smooth wall and contained a thin watery fluid—sp. gr. 1004, alkaline, albumen 2·5 per 1000. It resembled a parovarian cyst except in the depth of its situation in the right broad ligament, and in its close relationship to the body of the uterus.

You will observe from the previous history of this case that she had been troubled for a year with prolapse, and she was sent up to the hospital for that complaint because the prolapse could not be kept back by means of rings and other pessaries. There was not sufficient explanation of it in the condition of the vagina and perineum. But she had a pelvic tumour, and I think that was really the cause of the prolapse. On admission the uterus was so much prolapsed that the cervix was protruding from the vulva, and there was much elongation of the supravaginal cervix. Between the body of the uterus and the back of the bladder was a rounded tumour, which it was very difficult to define, because of the amount of fat in the abdominal wall. There was resonance above and also in front, and the tumour seemed far back in the abdominal cavity with the bowel coming down in front of it. We could also make out that the upper limit was about half-way to the umbilicus. The chief points to notice in this case were:—

1. The tumour had a very intimate union with the uterus. It was so glued to it that any slight pressure on the abdominal wall was conveyed at once to the cervix.

2. The uterus was retroverted and prolapsed by the tumour.

3. Its cystic characters were not distinct, partly because we could not feel it well bimanually owing to obesity, but on the whole the examination gave the idea that it was a cyst.

4. Notice that it was between the uterus and the bladder. To this point we will return.

5. There was no history of menorrhagia. Her youngest child was twenty years old and she had passed the menopause some seven years.

Now, with regard to the diagnosis, I thought it was a cystic fibroid tumour, because it was intimately united to the uterus. It was on the anterior aspect of it, therefore in a very likely position for a fibroid to grow. The uterus was retroverted and prolapsed by the weight of the tumour in front of it. In opposition to that view was the fact that she had never had menorrhagia, and that is a point of some importance. It should also be noted that it was after the menopause the trouble began. We might as an explanation assume that the tumour developed very near the surface of the uterus, and so had quickly become subserous. Moreover the recent onset of symptoms might be attributed to cystic degeneration of the tumour. I thought it was a case of cystic degeneration of a uterine fibroid occurring after the menopause—a well-recognised condition which you must bear in mind. If a fibroid has undergone cystic degeneration it will get larger and continue to do so. But we were wrong again. It was a mesometric cyst in the base of the right broad ligament, very deep down along side of the uterus, and intimately united to it. The operation consisted in tapping the cyst, enucleating its wall from the broad ligament, and tying off its deep connections, although there was *no* real pedicle. There were no adhesions to bowel. It was not a true parovarian cyst, but one deeply placed in the broad ligament along side of the body and cervix of the uterus.

Now let us consider the diagnosis of this case. The intimate union of the tumour to the uterus was, as I have said, strongly in favour of a fibroid. But the anterior position of the cyst has to be explained. How could a cyst growing in one or other of the broad ligaments come to lie so much in front of the body of the uterus? By means of rotation of the latter on its long axis. As the cyst expands the uterus has to accommodate itself, and becomes rotated upon its long axis until the cyst lies in front. This is a common event in the development of a broad ligament cyst, and thus it can simulate a subserous fibroid. Further, a fibroid is a much more likely cause of prolapse than an ovarian cyst, because the latter is expansile and tends to rise up in the abdomen, its tendency is to pull the uterus up. But there are a few exceptions to this rule. Thus, where an ovarian occurs in a young child it is very likely to cause prolapse, because the abdominal wall of a child is firmer and more resistant than that of an adult and tumours at that age grow rapidly. Hence there is more intra-abdominal pressure, and some of the worst cases of

prolapse in girls before puberty have been brought about by rapidly growing ovarian tumours. Another exception would be dermoids but they are not always true cysts. Many of them are stuffed with hair, and are therefore practically as solid as a fibroid; others may contain much calcareous tissue and so may be extremely dense. Others again might become so adherent from inflammation in the pelvis as to be prevented from rising, and therefore prolapse might occur. But as a rule ovarian cysts do not cause prolapse. If the prolapse be due to a pelvic tumour, that tumour is much more likely to be a fibroid, particularly if it be on the anterior or the posterior aspect of the uterus. Here we had a cyst which was not free to rise out of the pelvis. It was under the peritoneum at first, therefore in attempting to rise it had to elevate the peritoneum with it, and thus there would be a continual resistance, with the probability of its causing prolapse of the uterus. The absence of any history of menorrhagia we need not trouble about, because such an occurrence with fibroids is by no means uncommon. I do not think the diagnosis of cystic fibroid was a bad one under the circumstances. But I want to call your attention to the fact that it may be simulated by something else.

The third case was that of a more ordinary ovarian tumour in its general characters. I have sketched the outline of it, and you will notice at once that it is very unilateral.

CASE III.—MESO-SIGMOID CYST.

History.—Miss J., æt. 20, admitted for pain and swelling of the abdomen. Six weeks before admission she was suddenly taken ill with severe pain in the lower part of the abdomen and had to go to bed. The abdomen became distended and very hard. But after a week's rest she improved and has had no similar attack of pain since. Menstruation normal. No vaginal discharge. Micturition normal. Bowels regular except during the first fortnight of this illness.

On admission.—There is a rounded abdominal tumour rising out of the pelvis and extending to one inch above the umbilicus. Its right margin corresponds with the outer edge of the right rectus muscle, but on the left side it reaches out to the top of the left iliac crest. The tumour is fluctuating and somewhat movable, but its edges are not well-defined. There is a distinct thrill to be obtained. The uterus is retroverted and pushed down by the tumour above it, and the right vaginal fornix is much broader than the left because the cervix is drawn over to the left side.

Diagnosis.—The tumour was regarded as an ovarian cyst and operation advised.

Operation.—The abdomen was opened and after separating some adherent omentum a cyst was found between the layers of the meso-sigmoid with a coil of large intestine (sigmoid) running over the top of it. The cyst was tapped outside this coil and nearly two pints of dark brown fluid drawn off. The cyst could then be traced downwards into the left broad ligament. It had the left Fallopian tube running across its lower and outer aspect, while the sigmoid and upper rectum bounded it on the right side. The outer layer of the meso-sigmoid was incised and the peritoneum was gently peeled off. To facilitate the enucleation of the cyst, an incision was made into it and the cavity sponged out. Working then with one hand in the cyst and the other outside, the cyst was gradually dissected out of its bed. There was *no* pedicle, and bleeding points were secured when seen. Finally the incision in the outer layer of the meso-sigmoid was closed with a fine suture. The patient made a good recovery from the operation.

The cyst had probably originated from the left ovary. It consisted of one large cavity with several small loculi in the walls of the main cyst. It had grown at first between the layers of the left broad ligament and so stretched the Fallopian tube over it. Ultimately it had extended between the layers of the meso-sigmoid and so pushed the sigmoid and rectum forwards and to the right. On grasping the sigmoid the cyst was seen to bulge out on both aspects of the meso-sigmoid, but the portion below and outside the sigmoid was the larger. Part of the left tube was removed with the cyst, to which it was closely adherent. The right ovary and tube were normal.

The chief points in this case are: —

1. The cystic characters of the tumour were quite distinct.

2. Its markedly unilateral position (left iliac region).

3. It rose out of the pelvis to a little above the umbilicus.

4. It seemed far back in the abdominal cavity, and its outline was peculiarly indefinite, so much so that the mapping out of the tumour was chiefly done by percussion.

5. The uterus was displaced by traction, not by pressure. On vaginal examination the fornix on the right side was very much broadened, because the cervix was drawn over to the left. It would be natural to conclude that this displacement was due to the pressure of the tumour, but it was not so, for the uterus was on the same side as the tumour. The operation

showed that this displacement was due to the traction of the broad ligament cyst.

6. Attacks of abdominal pain like intestinal obstruction. The patient had an attack of abdominal distension and pain, with obstruction of the bowels, lasting for some fortnight. She was at work when the attack came on, and it was so sudden that she had to leave off at once and go home. About six weeks later she was suddenly attacked again, and was ill. During that time her abdomen had become swollen a good deal; there was pain, and she had considerable trouble in getting the bowels to act.

At the operation we found what I have sketched on the board. There was a large cystic tumour rising up from the pelvis into the abdomen, and the top of it was crossed by a coil of large intestine, which could be easily traced as the sigmoid flexure to the rectum. It was recognised by its broad band of muscle, and by its appendices epiploicæ. The tumour was therefore between the layers of the meso-sigmoid. The displacement of the uterus was due to its being drawn to one side by the cyst growing between the layers of the broad ligament. There are three ways in which an ovarian cyst may be connected with the broad ligament. Firstly, it may be inside the broad ligament and you should then call it a broad ligament cyst. Secondly, it may burrow into the broad ligament, and the latter may become distended in that way. Probably that was the case here. Thirdly, the cyst may gradually develop underneath the broad ligament. I have seen this happen on two or three occasions. As the enlargement of the cyst goes on, it carries the broad ligament up in front of it. The Fallopian tube and the broad ligament are thus stretched and gradually pulled up until they form a definite capsule or covering over the anterior aspect of the cyst, which is composed of *both* layers of the broad ligament. No doubt this is due to adhesions in the first place. The ovarian cyst is adherent underneath the broad ligament, and as it grows larger it displaces the ligament upwards. The Fallopian tube will then be found running over the top or even on the posterior aspect of the cyst. The appearances at first sight are those of an intra-ligamentous cyst, but careful dissection will show that it is not so, because you can separate off the two layers of broad ligament from the front of the tumour. I have called this tumour a meso-sigmoid cyst because that was its main position, but I do not think it originated there. Probably it developed in the left ovary, then burrowed into the corresponding broad ligament, and gradually extended upwards beneath the sigmoid flexure.

There are several varieties of broad ligament cysts which you should be able to mention.

(*a*) The true parovarian cyst.

(*b*) Cysts which arise from the hilum or the medullary part of the ovary, and are known as para-oophoritic or hilum cysts. They are situated from the first between the layers of the broad ligament, and gradually expand them.

(*c*) There is a third form, of which Case II. is an example, viz., the mesometric cyst, probably arising from Gærtner's duct. They are called mesometric to distinguish them from those of the mesosalpinx, the former being below the level of the ovary, and the latter above it.

(*d*) There is a form known as "outer-pole ovarians." They seem to arise from the outer pole of the ovary, and not from the whole body of the organ. They are between the layers of the broad ligament or mesosalpinx from the first, and are frequently mistaken for parovarians. I had one sent to the laboratory a few days ago, with the statement that it was a parovarian cyst, but it was really one of these "outer-pole" ovarians, and you will see that its relations are different from those of a true parovarian cystoma.

(*e*) Then we may have a few rarer causes, such as fibroids, which have become intraligamentous, and are so cystic as to be indistinguishable from an ovarian. There are others also, such as hydatids, cystic sarcomata, etc., which we need not detail here.

In Case III. the cyst was an ovarian, which had burrowed between the layers of the broad ligament. I say so for two or three reasons. In the first place, it was undoubtedly multilocular; we found several loculi. Parovarian cysts should always be unilocular. Secondly, the examination of its wall in different parts

showed muscle tissue such as would be derived from the broad ligaments, and it also showed remnants of true ovarian tissue. Thirdly, the character of the fluid was ovarian, a thick, dark-brown, and decidedly mucoid substance, not the thin watery liquid which one gets in parovarians. So that from its anatomical position, the presence of ovarian tissue in one part of its wall, and the character of the contents, we concluded that the cyst was ovarian in origin, although it had grown in between the layers of the broad ligament and travelled so far as to lie underneath the sigmoid flexure.

In Case II. the cyst was unilocular and the characters of the fluid were those of a parovarian cyst, very thin, watery fluid of extremely low specific gravity, and with a small amount of albumen—2 parts in 1000. The chief point against its being a simple parovarian was its situation. As a rule a parovarian does *not* grow down along side of the cervix. I have called it a mesometric cystoma because of its low position in the broad ligament. It had no pedicle, and was probably Gartnerian in origin. The resemblance between such a cyst and a parovarian is very great. Both are derived from the same fœtal relics and will exhibit the same histological characters in the cyst wall.

I need not go into the pathology of Case I. because it does not belong to the pelvic cavity. It was a retroperitoneal cyst but not pelvic in origin.

Now, with regard to the operation in such cases, these are the important points. Firstly, the cyst has *no* pedicle, therefore there is nothing which you can ligature in the usual manner. That must put you on your guard, because you may be expecting to find something suitable for a ligature and fail. Notice in passing that the peritoneum is always MOVABLE over these cysts. Secondly, there are special risks about them arising from the displacement they produce of important organs. When tumours grow deeply in the broad ligament there is always the risk of their being in close relationship to the bladder and the ureters, as well as the bowel and pelvic vessels. Indeed, the tumour may be so low that the vagina or cervix may be touching it. The relations of these parts to one another may be so close that the bladder and the ureters have been wounded. Thirdly, if you do not thoroughly control the hæmorrhage, after the operation is over oozing will take place into the space from which the cyst was removed, thus forming a hæmatoma. That may not give rise to trouble, but on the other hand it may suppurate. Therefore, if the space is not dry when you have finished, leave in some kind of drain. If it is sufficiently near the vagina you can make a small aperture in the vaginal fornix for the gauze drain. In all cases be careful to close over the top of the space with peritoneum securely. By leaving it open a piece of bowel may become incarcerated in the space.

Lastly, there have been many cases in which it was quite impossible to get down to the bottom of an intraligamentous cyst. What should be done under those circumstances? If the cyst comes easily to the front, some surgeons would suture its wall to the abdominal wall, and drain it in that way. But that is an extremely tedious process of cure and there is a risk of prolonged suppuration. If the cyst can be drained from below, it will be much better to close over the top of the sac, as is done in the operative treatment of some hydatid cysts in the abdomen.

In the Medical Wards.

Sydney, S., æt 20, a packer, was admitted on December 8th, 1902, into Stephen for pain in the epigastrium and shivering fits: patient was an adopted child and had had no illness to his recollection other than the present.

History.—On 23rd of November he was seized with *sudden pain in epigastrium. Previously he had had a* little indigestion. The pain lasted for several days and so patient was admitted into an Infirmary, and remained there for ten days. Morphia was given in the institution to relieve the pain. Obtaining no relief, patient left the Infirmary on the 6th of December, and went to bed at home and was seen by Dr. Johnson. His temperature was up to 102·4°. The diagnosis seemed to his doctor to be perforated gastric ulcer and subphrenic abscess. He was advised to come to Guy's, and was admitted. He describes the pain as a dull aching pain which at times "catches him" in the ribs. He was sick several times at home, and since the 23rd of November up to his admission had had five rigors. Bowels constipated. No hæmatemesis.

On admission.—Pulse 112; Respiration 20; Temperature 96·8. (101° at Out-Patients). Patient is a thin pale looking young man with rather sunken eyes and contracted pupils. No jaundice present. Tongue moist and brown. Breath foul, and sweating is profuse. The left leg fully extended, the right semi-flexed, the abdomen does not move well on respiration, is slightly rigid, more so in the epigastric and left hypochondriac regions, where there is marked tenderness; no peristalsis and no obvious swelling. Some slight tenderness on deep palpation in right iliac fossa. The liver appears to extend much below the costal margin. The spleen cannot be felt; liver dulness begins at 5th rib. No blue line present on gums and knee-jerks brisk. Blood count 12,500 leucocytes. Urine normal.

Heart.—Impulse in 4th space one inch internal to the nipple, otherwise normal in position, reduplicated first sound at impulse, and a soft systolic bruit in the 2nd left space. *Respiratory system.*—Breathing thoracic, T.V.F. absent below angle of scapula on right side. There is dulness at both bases, particularly on the right; numerous rhonchi are present all over the chest; air entry is diminished at bases, and there is some increase of voice-sounds at the level of inferior angle of right scapula. Crepitating râles can be heard in the anterior axillary line on the left side. Other systems normal.

On December 10th, patient had two rigors, on the 11th three, on the 12th two, on the 14th one. The highest temperature reached was 102·6°. From the 15th to the 21st he had two rigors, on the 11th the leucocytosis was 17,060, and on the 12th 31,250. Patient seemed in much pain and the heart impulse had moved and was now 1½ inches from the nipple in the 4th space. Mr. Steward was called in, and decided to explore the abdominal cavity. A median incision was made from the ensiform cartilage to the umbilicus. The stomach was normal. No pus could be found anywhere, and there was no signs of peritonitis. Some enlargement of the liver was observed and the organ looked congested. There did not seem to be any degree of resistance or inequality about its substance. The veins of the stomach seemed engorged, and there was a slight enlargement of the head of the pancreas, but no pus was detected behind it. The wound was accordingly stitched up. The needle was passed into the right pleural cavity, but no fluid found. It was thought that if pus were present it was in the liver. The next day the leucocytosis fell to 9,375. Patient fairly comfortable.

14th, leucocytosis 17,925.

15th, patient had a rigor and sweated profusely, leucocytes 18,750, temperature 102°.

16th, patient complained of pain as before, temperature 101·4, leucocytes, 19,375. R.E. revealed nothing abnormal. The heart showed signs of failing.

17th, leucocytes, 15,312, and patient more comfortable.

18th, temperature 104·2, a rigor and 32,184.

19th, leucocytosis 9,312. A differential count gave the following result:—

Polynuclear	253 ...	50·6 per cent.	
Small lymp.	98 ...	19·6	„
Large lymp	32 ...	6·4	„
Finely granular Oxyphile	95 ...	19	„ These cells were distinct from the Polynuclear variety.
Coarsely granular Oxyphile	22 ...	4·4	„
	500	100·0	„

21st, leucocytes 13,000. Patient seems better and wound is healing.

23rd, Rigor to-day. Temperature, 102·4.

To 31st of December patient had a rigor daily, and the temperature oscillated, reaching its maximum in the evening, generally about 102°. The lung conditions seem to have disappeared except the bronchitis. January 2nd, leucocytes 13,400; considerable amount of sputum. No tubercle bacilli to be found. The right base behind seems to be again dull, but patient's general condition has improved; patient remained in this condition until January 15th, when he refused treatment and went home. Latterly he improved considerably, and could eat minced chicken and sit up in bed. He became very troublesome, clamouring for morphia every night.

The case presents several interesting points. The rigors, profuse sweating, and general appearance of the patient indicated a severe septic process, and yet no pus of any kind could be found anywhere. The sudden onset and the position of the pain indicated a possible perforating gastric or duodenal ulcer, yet these organs were perfectly normal. The general impression was that suppurative pylephlebitis was most likely the diagnosis, although the primary focus was obscure. Patient, however, made such a good recovery that this seemed scarcely possible. He was extremely neurotic and simply craved for morphia.

Since patient's discharge the following facts are added by his medical attendant. Pulse and temperature are both normal. No pain except over site of the scar. There is a patch of dulness at the left base with fine consonating râles suggesting phthisis. Patient is steadily improving.

On March 1st, Mr. Steward saw the patient. He then stated that since leaving the hospital the pain in the abdomen had gradually left him and that he had steadily improved in every way, until the middle of February when a rash appeared on the body. When seen the patient exhibited a well-marked secondary syphilitic eruption on the trunk and limbs, enlarged hard glands in various parts of the body, and an indurated sore on the glans penis.

GOLDING-BIRD GOLD MEDAL AND SCHOLARSHIP, 1902.—Mr. Eugene John O'Meara was awarded a Special Certificate.

The use of Oxygen in a case of Empyema.

I FIRST saw the patient, Mr. G. B., aged 21 years, on April 13th, he had then been ill since March 12th, when he was first attacked with pleurisy, and from the charts shown me I saw that his temperature had been oscillating between 104° and normal for over ten days. On going over his chest, the usual signs of fluid on the right side were found, and later in the day a diagnosis of empyema was confirmed by putting in an exploring needle at the angle of the scapula and drawing off a syringe full of thick yellow pus. On April 15th, my partner operated, excising an inch or so of the eighth rib to the axillary line. The next day the temperature had fallen to normal, and except for reaching 99° twice, remained so until 1st day of May, when it started going up to 103 and 104°. A careful examination failing to reveal any complication, it was thought that, although the drainage tube had been still kept in, insufficient drainage and retention of some pus was the most probable explanation, so another anæsthetic was given and the wound duly opened up, more rib being removed by Lane's bone forceps, but we were disappointed by not finding any pus.

Despite a free use of the exploring needle and repeated examination the pus could not be located and the temperature continued up for over a week, until one day on pinching up the skin of the back, some œdema (a sign frequently demonstrated by Dr. Pitt) of the tissues was noticed on the right side above the level of the sixth rib, and on putting in a long (over 4 inches) exploring needle, pus was at last found. A third operation was performed and about a pint of very foul pus let out, with the usual result that the temperature returned to normal, the pulse became slower and the patient's appetite returned almost at once. But after a week of this satisfactory state the temperature again shot up to between 99 and 101°, the discharge at the same time becoming excessively offensive. I felt very tempted to wash out the cavity with some dilute antiseptic, but bearing in mind the occasional fatal results of this treatment, I determined to try oxygen, the use of which in a somewhat similar case was recorded in the *British Medical Journal* of May 2nd, 1903.

I introduced a new No. 6 gum elastic catheter into the cavity and connected this with an ordinary cylinder of oxygen and allowed a steady stream of the gas to flow into the chest. Almost immediately one striking result was seen. The oxygen appeared to create an increased pressure in the cavity, with the result that the pus was literally forced out; of course in an ordinary straightforward case of empyema drainage, provided enough rib is excised, is usually satisfactory, but here was a case in which the pus-containing cavity was several inches from the surface, and although a large drainage tube had been put in, pus would nevertheless collect; however, the oxygen was always most successful in forcing the retained pus out, and this without causing the patient any distress at all, there being no sign of dyspnœa nor faintness. I continued the use of the oxygen for 10 or 15 minutes daily, and in four days the pus was no longer offensive the granulations of the wound had become healthy, and the temperature had returned to normal and the patient is now making a good recovery.

J. A. HAMMOND.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Beds Supported by the Disguysed Minstrels.

DEAR SIR,—In the office of the Secretary to the Treasurer there are lying two brass plates which have recently been taken down, as the money for the support of the two beds which they represented is no longer forthcoming. I refer to the two brass plates which announced that the funds necessary for the support of the two beds were supplied by the Disguysed Minstrels. This Club, during the years 1896, 1897, and 1898, collected the net total of about £800. Of this, £500 was set aside to endow the cot in Astley Cooper ward, and the remaining £300 was handed over to the Treasurer to support two beds for the ensuing three years.

It was felt at that time, perhaps with some justice, that the public had for the nonce seen enough of that assembly of mountebanks, and the appeal was in danger of falling flat if the performances were continued every year without intermission. It was therefore decided to dissolve the club for three years and give the next generation some opportunity of working again in fresh ground and with the benefit of comparative novelty. The three years have come and gone and there is still no sign of a renewal of that public appeal by the students of Guy's Hospital every Christmastide. The last member of that old troupe of niggers has recently left the Residents' table, and a new generation has arisen which is entirely distinct from the one of five years ago of which I am speaking at the moment.

I feel sure that patriotism at Guy's is no less than it was in those days, and though talent of the vocal or dramatic sort is apparently rarer than formerly, the occasion will most probably produce the men. Under the circumstances, Sir, I would ask the favour of your columns to remind all men now at the hospital that at least £100 a year should be so raised by them to support and continue the work started by their predecessors and to save them from the slur of retrogression. The form of entertainment, the time, and place do not matter in the least as long as the two beds still get their £100 a year. With these few words of reminder I leave the matter in the hands of the Guy's Students of to-day.—Yours truly,

Ω.

Passim.

We publish on the first page an account of the arrangement made for the "Star" performance at His Majesty's Theatre by Mr. Tree and his company reinforced by some well-known names.

The King and the Prince will both be there for certain, and it is hoped the Queen and the Princess may also come. The performance has been fixed at 8.45 especially to suit the King, who is anxious not to miss any part, and his punctuality is so proverbial that it is anticipated everything will pass off without a hitch and be over at eleven thirty.

From the subjoined programme it will be seen that a wondrous cast has been gathered for the Laureate's first essay as a playwright. Mr. Tree himself has, we regret, been obliged to relinquish the part of James IV. to Mr. Fred Terry, but such well-known and deservedly famous actors as Mr. Oscar Asche, Fisher White, Henry Ainley, and Lionel Brough, to say nothing of Miss Constance Collier, will appear.

The performance takes place under the patronage of the President of Guy's Hospital, H.R.H. the Prince of Wales.

The seats have gone like wild-fire, and at the time of writing all the cheaper seats are gone, except an odd one here and there, and there are but a few three-guinea seats left. The great newspapers even have with great kindness taken the requisite seats for their dramatic critics, that no deduction whatever should mar the success of this splendid effort.

The opportunity of seeing the King, the Queen, and the leading rank and fashion at what almost amounts to a State Performance, added to the attraction of a first night, has driven the lucky ticket holders to a great state of anticipation and excitement.

By the kindness of a Governor, who has discreetly veiled his personality, ten pounds worth of tickets were placed at the disposal of the Residents, and by the personal efforts of Mr. Bonsor and others, seats for all the Sisters have been procured, by the generosity, we believe, of a well-known Governor, whose personality is familiar to all, though he wishes his identity hidden.

A member of the Staff, and yet another Governor, mindful as ever, we are proud to say of the claims, silent but still strong of the rank and file, bought the entire gallery for the free use of the Nurses and Students. It has been arranged instead that sixty seats in the pit shall be allotted to such Nurses as are off duty, this number representing the very utmost that can be spared, and that the first sixty applicants of the Students shall receive a seat each free, on condition they find some friend, or preferably some lady for whom they will pay four shillings for the adjoining seat. That is, the seats will practically be sold in pairs at two shillings a seat, so that at least sixty Students have a chance of being present.

If there is a demand for more seats, the gallery will be taken at two shillings a seat, each numbered and reserved as in the pit and elsewhere, and there will be no restriction on the number purchased by any who want to take a party or wish to purchase tickets for any friend outside. They may be bought by students, nurses, or anyone who desires them. We shall be very much surprised if this splendid offer is not readily grasped, only the application must be prompt, as in the absence of sufficient application the gallery will not be taken, but will be opened to the general public unreserved. We hope in our next to be allowed to publish the names of the very generous people who will have given the Sisters and Nurses so much enjoyment at so magnificent a function.

THE programme has been specially designed and will be a memento of unusual interest with photographs of our President (The Prince of Wales); the Treasurer (Mr. Bonsor); the Poet Laureate (Mr. Alfred Austin); Mr. Rudyard Kipling, and also of the popular and well-known actor manager, Mr. Tree.

LAST of all an adaptation of the one and only Rudyard Kipling, whose "Light that Failed" has recently been so successful, will follow the epic of his greatest rival. The Muse of the courtly and stately Laureate will shew a very sharp antithesis in style to the modern virile but often uncouth style that has rendered the Poet of Manhood and the Empire so famous.

WE are requested to state that the Annual General Meeting of Guy's Hospital Ladies' Association will be held in the Governors' Committee Room on Thursday, June 11th, at 4 o'clock. Mrs. Benyon will preside, and it is hoped that a large number of members will be present.

THE progress of the South African Memorial has afforded the quidnuncs on the colonnade steps considerable interest and scope of wit. Even among such censorious critics, who in their leisured ease survey the world through cynical spectacles and treat passers-by and passing events with equal levity and superiority, the general impression is deemed favourable, and though it may be necessary to endue the colonnade with a much needed coat of paint to harmonise with its somewhat dainty appearance, it is expected that by Prize Day the Memorial in its fullest and most perfect grandeur will have been completed, and the plumbers will have "made good" the water connection.

THE Committee will shortly be summoned to decide the nature and extent of the opening ceremony, so that our forecast is but the "intelligent anticipation" of our late Foreign Secretary, but probably an address worthy of the occasion will be delivered on Prize Day preliminary to the unveiling and handing over of the Memorial to the Hospital. It is anticipated, and we hope with truth, that the customary Prize Day speeches will be curtailed to allow of this, and we rather expect a consulting physician or other eloquent speaker to deliver an address that may be worthy of the occasion, and that we may be able to reproduce the design in the following issue of the GAZETTE.

THE Library is the richer by two bound copies of the *Guyoscope* which Dr. Stevenson kindly presented after perusing a note in our last issue. We are, however, still beggars for the odd copies that are required for the Bodleian Library, Oxford.

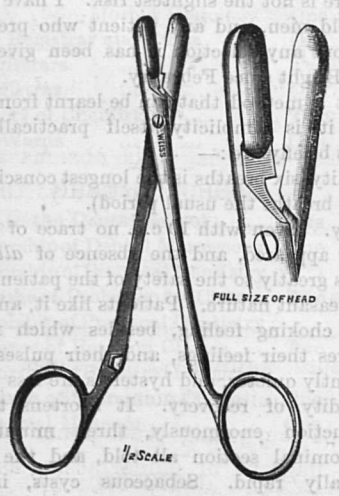
THE Metropolitan Asylums Board has taken a step with regard to the training of Medical Officers of Health that is highly to be commended. Seeing the tendency, and the praiseworthy tendency, for them to become experts in infectious diseases, it is obvious increased training is essential. Practically, the Junior Assistant Medical Officer's post is now put at their disposal, and this supplies the clinical work that has been for so long denied medical students and practitioners. Let us hope that in the future, training at the Fever Hospitals will include similar clinical work, and then the mistakes of the young practitioner will not be either so flagrant or embarrassing as they frequently are, whether in the Front Surgery or at the most illiberal area of surrounding criticism in general practice. The only criticism is that board and residence should not be the

only remuneration for the work done. Otherwise the imputation will be fairly made of a somewhat mean method of economising the present medical officer's salary.

We have received some anonymous contributions and regret that the talented authors have withheld their names. This is regretable for two reasons. The incognito of all effusions dropped into the colonnade box is absolutely inviolate, no one but the Editor ever seeing the contribution. Secondly, it frequently happens that a contribution is not acceptable in the exact form in which it arrives, but can be easily altered to suit, but if the author is unknown this cannot be done. This applies to a Lighter Vein that reached us anonymously, parts of which are open to criticism, but which, however, are easily remediable.

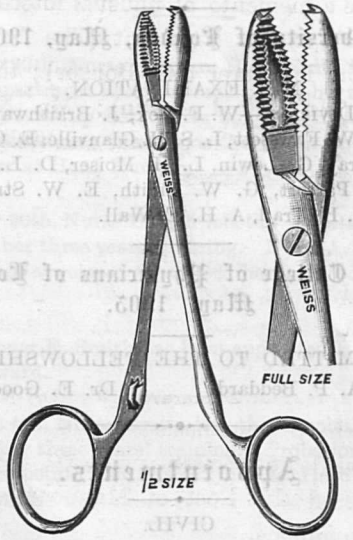
Novelties.

LANE'S BONE FORCEPS.



By inadvertence in our last issue, we published a plate purported to be a representation of Lane's Bone Forceps, but though a casual glance revealed no difference, there is a distinct difference on closer inspection. Above will be found the genuine instrument.

LANE'S MODIFICATION OF SPENCER WELLS' FORCEPS.



The above modification of Sir Spencer Wells' Forceps is furnished with a toothed catch at the end. Spencer Wells are apt not to bite just at the spot where the grip is essential, and these most excellent instruments have given great satisfaction where used.

GILMOUR'S OATMEAL STOUT.

When subjected to analysis, this was found to be exceedingly well ærated; the amount of alcohol was well up to the average; no preservatives were present. The specific gravity was rather low, as was also that of the "original wort." No arsenic was present. All the results obtained by analysis shewed this to be a good, wholesome beverage. Trying the stout practically all those who took it approved very highly of it, and several patients are still taking it with great gusto. In convalescents who like beers it is an excellent and reliable drink.

"AVOCA" CIGARS.

The "Avoca" cigars are a special brand grown on a particular soil, and are guaranteed to be free from arsenic.

About cigars, the best of friends will differ, but there is no doubt that these are extremely smokable, and that the freedom from arsenic has been obtained. Trial by incineration has been made in the ordinary way by the mouth, and we have received a most favourable report as to their quality, and though strictly speaking tobacco should not be a recommendation of the scientist, we have no hesitation in approving of these.

Pass List.

University of London, May, 1903.

M.B. EXAMINATION.

SECOND DIVISION.—W. F. Box, J. Braithwaite, H. S. Brown, F. W. Fawssett, L. S. H. Glanville, E. G. Goldie, A. C. H. Gray, G. Lewin, L. H. Moiser, D. L. Morgan, H. McD. Parrott, G. W. Smith, E. W. Strange, H. Tipping, D. H. Trail, A. H. E. Wall.

Royal College of Physicians of London, May, 1903.

ADMITTED TO THE FELLOWSHIP.

Dr. A. P. Beddard. Dr. E. Goodall.

Appointments.

CIVIL.

BIDDLE, H. G., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer and Public Vaccinator for the St. Peter's District of the Isle of Thanet Union.

STAMFORD, R. B., F.R.C.S. Edin., L.R.C.P. Lond., M.R.C.S., has been appointed Honorary Medical Officer to the Loughborough and District Hospital and Dispensary.

*** We regret that in our last issue currency was given to the erroneous announcement that Mr. Biddle had been appointed Medical Officer of Health for Broadstairs.

NAVAL AND MILITARY.

Surgeon A. W. IREDELL, R.N., has been appointed to the *Duke of Wellington*, for Haslar Hospital.

Mr. FREDERICK S. BRERETON (late Captain, Royal Army Medical Corps), to be Captain in the 3rd V.B. the King's (Liverpool Regiment), and Surgeon-Lieutenant J. P. PENDLEBURY, of the same battalion, resigns his commission.

Lieutenant H. W. WEBBER, Volunteer Infantry Brigade Bearer Company, Devon, to be Captain.

Papers by Guy's Men.

A Clinical Lecture on a Case of Displacement of both Testes in Perineo. By Clement Lucas, B.S., F.R.C.S.—*The Clinical Journal*, 3rd June.

An Address on the Disposal of the Wounded in Naval Warfare. By Philip N. Randall, M.B. Lond., late Surgeon, R.N.—*The Lancet*, 23rd May.

On Some Factors in Bacteriolytic Action. By E. W. Ainley Walker, M.A., M.D.—*Journal of Hygiene*, Vol. iii., p. 52, 1903.

Induction of Anæsthesia.

IN the last sixty operations that it has been my lot to give the anæsthetic for, I have given a serious trial first to Somnoform, and then to Kélène, as a preliminary to either ether, A.C.E. or chloroform. Several medical men who themselves have had other anæsthetics before, and others who have had as many as ten, have been anæsthetised by this method, and their opinions are valuable. Without being able to dogmatise on such relatively short experience, I may give a preliminary account of the results, and later on, perhaps, amend with great experience this summary of facts.

I use a piece of lint (4 inches by 4 inches roughly), in a Clover's bag which I fit direct to a Clover's face-piece. It can be given on a special apparatus, or through a piece of lint wrapped inside a Clover charged with ether. My method dispenses with apparatus, and can be carried in a pocket easily. I use 3–4 c.c.s. of pure Ethyl Chloride (Kélène); up to 6–8 can be used, but is unnecessary; spray it rapidly on the lint in view of the patient, who with eyes open allows it to be clapped on the face *rapidly*. In 6–8 breaths consciousness is gone, no *smell* of anæsthetic is noticeable, and the sensation all assure me is very agreeable, and free from any feeling of *choking*. As soon as the pupil is fixed and glassy, or the arms are flaccid, or patient fails to respond to questions, the mask is replaced by a cone of A.C.E. or ether, which may be applied strong without difficulty or delay.

It is rare for *any struggling at all* to occur if it is properly given, and it has never failed. The pulse remains unaffected, and often also the respiration. I believe there is not the slightest risk. I have given it to children, old men, and any patient who presents himself: without any selection it has been given to every patient in Bright since February.

It is not a method that can be learnt from a description, but it is simplicity itself practically, and its advantages briefly are:—

1. Rapidity (six breaths is the longest conscious record, four breaths the usual period).
2. Safety. Even with 10 c.c. no trace of danger has ever appeared, and the absence of *all* struggling adds greatly to the safety of the patient.
3. Its pleasant nature. Patients like it, and have not the choking feeling, besides which its rapidity spares their feelings, and their pulses are consequently quieter, and hysterics are less common.
4. Rapidity of recovery. It shortens the time of induction enormously, three minutes for an abdominal section all told, and the recovery is equally rapid. Sebaceous cysts, iridectomies, cysts in the neck, tubercular glands, etc., invariably are perfectly conscious, even when Kélène is followed by A.C.E., before one has time to get them back to bed.

Kélène does not of itself leave any unpleasant sensation behind. Somnoform does; four c.c. will give nearly a

minute and a half, and in a prepared patient can be repeated continuously with safety.

Kélène and A.C.E. make an easier combination than Kélène and Ether for those who like A.C.E. (the usual anæsthetic at Guy's). Kélène is a proprietary drug, probably pure Ethyl Chloride will answer as well at exactly half the cost. The ordinary Ethyl Chloride spray has produced the same effect, but I am not satisfied as to its safety.

Against it:—

1. Its expense. 4d. an administration.
2. Possibly the want of muscular relaxation, though skilled continuous administration obviates this.

It requires some skill, but the practical points can easily be learnt by watching its administration two or three times, but not by reading descriptions of it, so I have not given any description of the method.

J. M. BRYDONE.

Notice.

VACANT STAFF APPOINTMENTS.

THE following vacancies for next October are announced. Applications should be sent to the Treasurer, the Superintendent's Office, Guy's Hospital, at or before 12 noon, on Thursday, June 11th, 1903:—

MEDICAL SCHOOL.

Demonstratorship of Anatomy	Two	Vacancies.
" Anatomy & Biology	One	"
" Physiology ...	One	"
" Biology	One	"
" Morbid Histology	One	"
Ophthalmic Registrar and Tutor ...	One	"
Medical Registrars	Two	"
Surgical Registrar	One	"
Demonstrators of Chemistry	Two	"
Analyst for Wards	One	"

DENTAL SCHOOL.

Anæsthetist to the Dental School ...	One	"
Demonstratorship of Dental Microscopy	One	"
Demonstratorship of Practical Dentistry with charge of Probationary Classes	Two	"
Demonstratorship of Practical Dentistry with charge of Revision Classes ...	Two	"
Demonstratorship of Practical Dentistry with charge of Extraction Classes	One	"
Curator of Dental Museum	One	"

HOSPITAL.

Anæsthetist	One	"

Gentlemen appointed to the above vacancies will be required to begin their duties on October 1st next. Further particulars may be obtained from the Dean,

J. FAWCETT.

Nursing News.

MATRON'S OFFICE.

On May 29th, Nurse Norman, Head Nurse in the Out-patient department left on completion of her three years' training to take up her duties on the Private Nursin Staff. Probationer Mackenzie has been appointed to succeed her as Head Nurse.

On May 30th, Nurse Hooper left the hospital on completion of her three years' training. Nurse A. R. Thompson has been appointed to succeed her as Head Nurse in Job ward.

Probationer F. Smith has been appointed Head Nurse in Philip ward.

On June 4th, Nurse Crowe left the hospital on completion of her three years' training. Probationer Morley has been appointed to succeed her as Head Nurse in Naaman ward.

On June 4th, Nurse Cook left the hospital after three and a half years' service. Probationer Pearse has been appointed to succeed her as Head Nurse in Lydia ward.

On June 4th, Probationer Heritage was appointed Head Nurse in the Isolation wards.

Change of Address.

Captain C. M. Fleury, Royal Army Medical College, St. Ermin's Hotel, Westminster, S.W.

Dr. W. Frank Colclough, has commenced practice at Bainton House, Sherborne, Dorset.

Francis G. Cross, F.R.C.S., has moved from Beckenham to Montpelier, Cranes Park, Surbiton, and started practice in partnership.

Dr. A. W. Clark, has moved from Wisbech to La Roche, Onslow Gardens, Wallington, Surrey.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Dr. THOMAS STEVENSON has presented the *Guyoscope* (two volumes, complete, bound in cloth) to the Library.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Types.

HALF-HOURS WITH GREAT MEN.

No. 10.—"THE AMOROUS ONE."

"In tendency to fall in love,
Resemble I the amorous dove."

"I'm so shy, so awfully shy,
So terribly shy you see!"

"In peace there's nothing so becomes a man
As modest stillness and humility."

I gave two gentle taps at the door and held my breath expectantly. A voice within said "P. O." The owner of the voice was apparently pre-occupied.

Now I am a polite person, and an Englishman's den is his castle, so, albeit the utterance was somewhat cryptic, I obeyed its most apparent meaning and p' o'ed, that is to say I repeated my gentle taps.

"Oh, come in! come in!" said the voice again in a delicious baritone, and my entrance at last was a fait accompli. But the great man was writing with a simple stylograph on a few Guy's slips.

"Excuse me one moment, I am engaged in a somewhat important task."

"Certainly, pray do not mention it I beg, I like it," and besides, the interval gave me a chance to inspect the apartment. It was neat but not gaudy. At each end of a somewhat ordinary mantelpiece were vases filled with wall-flowers, which scented the presence-chamber and gave an air of spring and filled one insensibly with a love of life. Between these and at an equal distance from each was a signed photograph of Wee Willy Winkle, before which two joss-sticks were burning.

The pattern of the paper on the walls seemed strangely familiar, but the pictures! oh, the pictures. Nurses innumerable smiled down on one from those walls, it was enough to make the most hardened browser turn green with envy.

But the great man was humming softly to himself as he blotted his Guy's slips. I recognised the tune—it was a hybrid—suggesting the Devout Lover and Baa-Baa Black Sheep. In another minute he had risen and was standing in a characteristic attitude—of course I mean an upright one—erect in gait and somewhat angularly.

"You wish to interview me?"

"If you will allow it."

"Oh, yes, certainly." (A pause followed.) Then he said suddenly, "Would you like soup, cocoa, or lemonade—it's a hot day."

"No, thanks, I don't drink; but a simple paper cigarette would do me no harm; and please tell me all about yourself."

He did not smile at this—he has no sense of humour—the great men are always the sad men.

"Well, to begin with, I am just completing my essay on 'Some aspects of the horse-hair stitch'—especially in connection with breast cases. I only took an hour to stitch up one of these latter the other day. Wasn't that grand?"

"Prodigious. Do you play honey-pots?"

"Ah, no; that exercise is too exhausting—for me. My one form of relaxation is to yearn. I am a great yearner."

"Ah, naughty, naughty! I am afraid you're a sad dog."

"Tee-hee" he laughed. "Oh, I am not as saucy as all that; but (impulsively) really you know girls are awfully nice. Aren't they?"

"Ah, but we are not all as fortunate as you."

"No, I know it is my helplessness that appeals to them. Do you think I ought to be more of a tin-god?"

"No, no," said I, earnestly, "the ladies like us to be natural. Be yourself or you are lost.

Be fussy, be childish; say P. O. continually; mildly curse your dressers; but tin-goddishness—no, no, that would be a fatal mistake."

"Yes, I suppose it would. I suppose it would."

He rose, and crossing to the mantelp ece, sniffed languidly at his wall-flowers, saying "P. O." after each sniff, and thus necessitating another, until I became alarmed at the constant repetition.

"Excuse me; but if you should be struck so."

"How funny that you should say that. My grandmother was in the habit of making that remark, when I playfully simulated torticollis. And, talking of torticollis, reminds me. Do you know I was intended for the Church?"

"I did not know for certain. I have always imagined that such must have been the case—from the shape of your head."

"Really. How clever of you. Do you think that is why the girls like me?"

"No doubt that would account for the affections of some of your maturer admirers."

"But in the main I should say it was your 'je ne sais quoi,' that fetches 'em."

He looked awfully pleased. "Oh! that's French—how nice—one of my dressers has been to Paris—he often goes there. 'My je ne sais quoi.' P. O! P. O!"

"Mr.—— wanted in the Front," shouted the implacable Copsy.

Immediately he was himself again—a thorough doctor from head to foot.—

"Well good-bye—so glad to have seen you—sorry I must go—stay and finish your cigarette if you are in no hurry—and you may read my essay if you like."

(Stopping in the doorway with a radiant smile—which only a great and good man could effect). "'My je ne sais quoi!' P—— O——!"

GOOSE SNIPER.

Sport.

Cricket.

GUY'S v. BLUE MANTLES.

Played at Tunbridge Wells on Wednesday, May 20th, and resulting in a win for us by 50 runs. The victory was largely due to some good bowling by Foster and Cowper, backed up by the field, some good catches being made. Scores:—

GUY'S.

H. Barber, b Carr	3
F. Morres, b Leney	48
A. L. Foster, b Carr	2
R. Willan, b Carr	31
M. MacPherson, c Hervey, b Leney	12
H. M. Langdale, b Leney	0
L. G. Davies, c Carr, b Leney	2
A. M. Tolhurst. c & b Havers	13
A. E. Causton, b Bent	12
E. A. Collins, c Kelsey, b Bent	14
C. M. L. Cowper, not out	1
Extras	3
Total	141

BLUE MANTLES.

E. L. Bent, b Foster	7
H. Leney, c Foster, b Davies	0
A. C. Havers, b Cowper	30
J. H. Kelsey, lbw b Foster	2
W. S. Gwynn, c Collins, b Foster	4
J. Carr, c Tolhurst, b Cowper	2
T. W. Mitchell, c Causton, b Cowper	18
F. P. Hervey, c Cowper, b Foster	1
Rev. W. Malden, c & b Foster	7
A. P. Braybrooke, c & b Foster	1
H. Soames, not out	0
Extras	18
Total	90

GUY'S v. R.I.E.C. COOPER'S HILL.

Played at Cooper's Hill, Egham, on Saturday, May 23rd. This was the first hard wicket experienced this season, and was much appreciated. O'Brien was very successful with his bowling, taking five wickets for 14 runs, thanks chiefly, however, to our opponents' eagerness to make runs. Scores:—

R. I. E. C.

C. E. Colbeck, b Davies	10
L. E. Becker, b Foster	10
F. A. Heyman, c & b Davies	28
H. S. Nicholson, c & b Foster	2
A. P. Manning, b O'Brien	15
R. Kirkpatrick, c MacPherson, b O'Brien	16
L. G. P. de Smidt, c Morres, b O'Brien	2

D. S. H. Mercer, b O'Brien	10
W. Sidebottom, not out	10
A. B. Madapa, b Davies	2
E. V. Ellis, c Langdale, b O'Brien	1
Extras	24
Total	130

GUY'S.

F. Morres, c de Smidt, b Ellis	63
R. Willan, b de Smidt	23
H. M. Langdale, c Manning, b de Smidt	51
A. B. O'Brien, b Sidebottom	11
F. Husbands, b de Smidt	6
A. L. Foster, c de Smidt, b Nicholson	4
M. MacPherson, not out	6
E. A. Collins, c Nicholson, b de Smidt	4
Extras	11
Total (7 wickets)	179

J. S. Bookless, L. G. Davies, G. Russell, did not bat.

GUY'S v. SURREY CLUB AND GROUND.

Played at Honor Oak on Wednesday, May 27th, and ending in a decisive win for the Club and Ground. Guy's won the toss, and after starting well, having 130 up for two wickets, only put together 168, out of which Barber made 82 in excellent style. An extraordinary collapse ensued in the quarter of an hour before lunch, 5 wickets falling for scarcely any runs. Scores:—

GUY'S.

H. Barber, c Clode, b Rushby	82
F. Morres, c Bale, b Rushby	16
J. S. Bookless, c Platt, b Hobbs	20
R. Willan, lbw, b Capt. Lewis	22
H. M. Langdale, run out	5
H. D. Wyatt, b Capt. Lewis	0
E. Morgan, b Rushby	13
E. A. Collins, b Rushby	0
M. MacPherson, b Rushby	0
A. Young, b Capt. Lewis	0
G. Russell, not out	2
Extras	8
Total	168

SURREY CLUB AND GROUND.

P. Harrower, lbw, b Wyatt	0
Abel, c Wyatt, b Bookless	90
Capt. Lewis, c Barber, b Wyatt	52
Hobbs, c Barber, b Wyatt	86
F. J. Cook, lbw, b Barber	12
C. Armitage Moon, c Wyatt, b Willan	24
Clode, c Wyatt, b Willan	10
S. Gaudy, b Wyatt	2
Platt, not out	5
Rushby, not out	2
Extras	5
Total (8 wickets)	288

Bale did not bat.

GUY'S v. REIGATE PRIORY.

Played at Reigate on Saturday, May 30th, and after a close and exciting finish, ended in a victory for us by the narrow margin of three runs. At one period 40 runs were wanted with four wickets to fall, and when Collins, the last man went in, 22 runs were still wanted. O'Brien, by playing a very sound and steady game at a critical time, was largely responsible for this result. Scores:—

REIGATE PRIORY.

R. W. Neale, b Morgan	23
F. Nightingale, b O'Brien	21
J. W. Neale, c sub., b O'Brien	51
F. J. Nightingale, b O'Brien	23
H. B. Walters, c Langdale, b Bookless	19
H. A. Barnes, b Foster	9
H. F. Wilgress, c Morres, b Morgan	4
F. J. Buckland, c & b Morgan	8
B. T. Kenward, not out	9
F. P. Auley, b Morgan	0
F. C. Morrison, run out	10
Extras	15
Total	191

GUY'S.

F. Morres, b Morrison	74
H. M. Langdale, b Morrison	26
R. Willan, c Buckland, b Morrison	3
E. Morgan, b Morrison	18
F. Husbands, b Morrison	2
A. B. O'Brien, b F. Nightingale	30
J. S. Bookless, b Morrison	4
M. MacPherson, c J. W. Neale, b F. Nightingale	4
A. L. Foster, b Morrison	3
E. A. Collins, not out	11
Extras	19
Total (9 wickets)	194

GUY'S 2ND XI. v. MANOR HOUSE SCHOOL.

This match was played at Tooting on May 13th, and resulted in a win for Guy's. Scores:—

MANOR HOUSE SCHOOL.

A. L. Gorringe, c Bartlett, b Piper	4
A. C. Dene, c Gibson, b Piper	3
S. Maxwell, b W. Greening	17
H. M. Gorringe, b W. Greening	6
W. B. Laird, c G. Greening, b W. Greening	8
F. L. Parsons, b Russell	1
A. A. Bennett, st Gibson, b W. Greening	4
H. C. Evans, b Russell	0
J. C. Page, not out	11
A. Martyn, c Taylor, b Russell	3
A. H. Tannaway, c Gibson, b Russell	0
Extras	6
Total	63

GUY'S.

H. M. Whittell, c Laird, b Bennett	0
G. Greening, b Laird	0
T. R. Harvey, c Bennett, b Laird	0
H. H. Moyle, b Laird	3
A. M. Tolhurst, c Martyn, b Parsons	23
H. G. Gibson, c Dene, b Laird	28
G. N. Bartlett, c Martyn, b Bennett	17
S. A. Piper, c Dene, b Gorringe	18
G. Russell, b Gorringe	9
H. Vernon Taylor, not out	0
Extras	2
Total (9 wickets)	100

G. W. Greening did not bat.

GUY'S 2ND XI. v. LONDON 2ND XI.

This match was played at Hale End on May 16th, and resulted in a win for Guy's. Scores :—

GUY'S.

A. M. Tolhurst, c Vevers, b Harrison	31
G. Greening, c O'Reilly, b Gibson	19
E. L. Norton, b Pollard	23
J. F. Young, lbw, b Gibson	0
H. G. Gibson, b Gibson	9
A. G. Allison, c Gayton, b Pollard	5
H. Leeming, not out	17
W. H. Miller, b Pollard	0
G. N. Bartlett, b Gibson	4
G. Russell, b Gibson	6
W. Greening, b Pollard	11
Extras	14
Total	139

LONDON.

Aspinall, b Bartlett	0
Watson, b Russell	0
Pollard, c & b Bartlett	8
H. Gibson, c Russell, b Bartlett	0
Hutchison, b Russell	2
Gayton, b Russell	0
Vevers, c Miller, b Bartlett	1
Mathews, b Russell	1
Harrison, not out	2
O'Reilly, b Bartlett	0
H. A. Brown, b Russell	0
Extras	3
Total	17

GUY'S 2ND XI. v. LONDON 2ND XI.

The return match between Guy's 2nd v. London 2nd was played at Honor Oak, on May 20th, resulting in a win for Guy's. Scores :—

LONDON.

Pollard, c Harvey, b Russell	0
Brown, b Greening	0
Harrison, b Greening	0
Day, b Russell	6
Gayton, b Russell	1
Gibson, lbw, b Young	23
Aspinall, b Russell	0
Waller, c Greening, b Young	7
Watson, c Brookhouse, b Young	8
O'Reilly, run out	2
Clarke, not out	4
Extras	2
Total	53

GUY'S.

H. D. Wyatt, c and b Gayton	34
A. G. Allison, b Gayton	20
T. R. Harvey, c Gibson, b Clarke	19
J. F. Young, b Gaton	3
H. M. Whittell, c Aspinall b Clarke	0
G. Russell, c Watson, b Gayton	21
H. O. Brookhouse, c Aspinall, b Gayton	3
G. N. Bartlett, b Clarke	1
W. Greening, run out	5
A. Vernon Taylor, c Pollard, b Gayton	0
H. N. Eccles, not out	0
Extras	13
Total	119

GUY'S 2ND XI. v. OLD OLAVIANS.

This match was played at Honor Oak on May 23rd, and resulted in a win for Guy's. Scores :—

OLD OLAVIANS.

Lugg, b Piper	0
Brownlow, b Piper	21
Trowell, b Wearing	47
Wakely, b Wearing	4
Lowe, b Bartlett	39
Sutherland, b Piper	6
Wilson, c & b Wearing	0
Howard, c Gibson, b Piper	2
Krauss, not out	7
Barton, b Wearing	0
Weston, b Wearing	0
Extras	11
Total	137

GUY'S.

A. M. Tolhurst, run out	3
G. F. Allison, c Brownlow, b Trowell	30
E. L. Norton, c Brownlow, b Lowe	15
H. G. Gibson, b Lowe	0
G. Greening, c Brownlow, b Barton	31
M. G. Louisson, c Brownlow, b Lugg	36
A. Leeming, not out	16
S. A. Piper, c Brownlow, b Trowell	3
G. M. Bartlett, not out	9
Extras	2
Total (7 wickets)	145

D. G. Wearing and J. F. Young did not bat.

GUY'S 2ND XI. v. R. I. E. C. 2ND XI.

This match was played at Honor Oak Park on 30th May, and resulted in a drawn game. Greening, Louisson and Moyle batted excellently. Scores:—

GUY'S.

H. H. Carter, b Madapa	4
A. Leeming, c Mercer, b Hart	1
G. Greening, c sub., b Mills	66
A. M. Tolhurst, b Hart	12
M. G. Louisson, c Mercer, b Teague	45
S. M. Wells, b Bell	1
H. G. Gibson, c Teague, b Hart	4
H. H. Moyle, c Casement, b Bell	24
D. G. Wearing, not out	5
W. Greening, b Burton	0
J. F. Young, not out	0
Extras	18
Total (9 wickets)	180

Innings declared closed.

R. I. E. C.

D. L. H. Mercer, c Wells, b Moyle	45
H. R. Blanford, b Wearing	23
E. D. Haffenden, c Tolhurst, b Moyle	5
R. H. Casement, not out	15
V. Hart, not out	5
Extras	1
Total (3 wickets)	94

A. B. Madapa, R. C. F. Burton, C. F. Bell, C. O. Towsley, F. Waller, L. E. S. Teague, did not bat.

GUY'S 3RD v. SEVENOAKS SCHOOL.

This match, played at Sevenoaks, on May 16th, ended in a win for Sevenoaks by 78 runs for seven wickets to 67 runs.

GUY'S 3RD v. BORO' ROAD COLLEGE "A."

This match, played at Isleworth, on May 23rd, Boro Road College winning easily by 40 runs.

Scores:—Boro' Road College "A" 71. Guy's 3rd, 31.

GUY'S 3RD XI. v. CAMBERWELL HOUSE.

Played at Camberwell on Saturday, May 30th, and ended in an easy victory for our opponents. Scores:—

GUY'S.

E. W. Strange, c & b Milton	2
A. D. Vernon Taylor, c & b Milton	17
P. R. Harvey, b Ross	4
G. E. Rice, b Ross	8
P. G. V. Pedrick, b Ross	14
P. H. Edey, lbw, b Milton	9
H. A. Watney, not out	8
D. Reynolds, b Milton	2
H. H. Whittell, lbw, b Milton	0
L. L. C. Reynolds, not out	0
Extras	10
Total (8 wickets)	74

Innings closed.

A. L. Gardiner did not bat.

CAMBERWELL HOUSE.

Mitchell, c Harvey, b Edey	13
Higgs, b Harvey	35
Ross, c & b Edey	4
Parsons, b Edey	15
Milton, b Edey	0
Raymond, run out	3
Sargent, b Harvey	10
Longford, b Edey	2
Stringer, not out	7
Moore, c & b Edey	4
Shapley, not out	2
Extras	25
Total (9 wickets)	120

Guy's Hospital Lawn Tennis Club.

On Saturday, May 23rd, we beat Wanstead, at Honor Oak Park, by 6 events to 3.

Lucas and Palmer beat McAdam and Lacey, 9–7, 2–6, 6–1; beat Eustace and Clark, 6–1, 7–5; beat Dobson and Brinkley, 6–1, 6–3. Earle and Zorab beat Eustace and Clark, 7–5, 6–0; beat Dobson and Brinkley, 6–3, 7–9, 8–6; lost to McAdam and Lacey, 3–6, 2–6. W. G. Pinching and Winckworth beat Dobson and Brinkley, 6–3, 6–2; lost to McAdam and Lacey, 0–6, 8–6, 2–6; lost to Eustace and Clark, 2–6, 6–0, 1–6.

On Wednesday, May 27th, Harold scratched their match against us, being unable to raise a team.

On Saturday, May 30th, Kent beat us by 7 events to 2.

Lucas and Palmer lost to Hook and Colquhoun, 6–3, 1–3, 4–6; beat Durnford and Kent, 4–6, 6–4, 6–2: beat Davis and Exham, 6–3, 6–4. Zorab and Earle lost to Durnford and Kent, 0–6, 9–7, 2–6; lost to Hook and Colquhoun, 3–6, 2–6. W. G. Pinching and Cutler lost to Davis and Exham; lost to Durnford and Kent, 2–6, 2–6; lost to Hook and Colquhoun, 3–6, 1–6.

On Wednesday, June 3rd, Boundaries beat us by 6 events to 3.

Lucas and F. Palmer lost to Johnstone and Christie, 6–2, 4–6, 4–6; beat Prideaux and Leonard, 6–4, 6–3, beat Bent and Hogg, 6–3, 6–1. Swan and Zorab beat Prideaux and Leonard, 3–6, 10–8, 6–1; lost to Bent and Hogg, 3–6, 6–8; lost to Johnstone and Christie 2–6, 3–6. Cutler and A. Palmer lost to Bent and Hogg, 3–6, 1–6; lost to Johnstone and Christie, 3–6, 1–6; lost to Prideaux and Leonard, 3–6, 5–7.

The Senior Inter-hospital Cup Ties have been fixed for June 24th, 25th, and 26th.

H. V. Mitchell has been elected secretary of the second six.

ED.—J. M. B.

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Calendar of Coming Events.

June, 1903.

Sat. 20.—Messrs. Symonds and Steward's take-in; Drs., R. Franklin and E. W. Routley; Cl., H. Tipping.
G.H.C.C., I., v. Past, 11 a.m., home.
II., v. Blackheath "A," 2 p.m., Blackheath.
III., v. Home and Colonial, 2 p.m., away.
G.H.L.T.C., I., v. Past, home.

Mon. 22.—1.15 p.m., Clinical lecture by Mr. Steward.

Tues. 23.—G.H.C.C., I., v. Hornsey, 11 a.m., Hornsey.

Wed. 24.—1.30 p.m., Clinical lecture by Dr. Shaw.
Annual Athletic Sports, 2.30 p.m.
G.H.C.C., II., v. St. Thomas's, 2.30 p.m., Chiswick.
G.H.L.T.C., I., v. Redhill "A," home.

Thur. 25.—Messrs. Lucas and Lane's take-in; Drs., G. H. Cheyney and R. P. Rowlands; Cl., B. H. Wedd.

Fri. 26.—1.15 p.m., Clinical lecture by Mr. Fripp.
G.H.C.C., II., v. Thespids, 11.30 a.m., home.

Sat. 27.—G.H.C.C, I., v. Old Cranleighans, 11 a.m., home.
III., v. Camberwell House, 2 p.m., away.
G.H.L.T.C., I., v. Brixton Wanderers, East Dulwich.

Mon. 29.—1.15 p.m., Clinical lecture by Mr. Targett.

July.

Wed. 1.—1.30 p.m., Clinical lecture by Dr. Bryant.
August and October Appointment Lists opened.
G.H.C.C., I., v. Gravesend, 11 a.m., Gravesend.
II., v. Kingston Hill, 11.30 a.m., home.
G.H.L.T.C., I., v. The Staff, home.

Thur. 2.—Second Conjoint Exam. begins.

Fri. 3.—1.15 p.m., Clinical lecture by Mr. Fripp.
Garden Party and Distribution of Prizes, 3 p.m.

Sat. 4.—G.H.C.C., I., v. Heath Asylum C.C., 11 a.m., Bexley.
II., v. St. Bart.'s, 2 p.m., Winchmore Hill.
III., v. Hos.-Scho., 2 p.m., home.
G.H.L.T.C., I., v., Brixton Wanderers, home.

Guy's Hospital Gazette,

JUNE 20, 1903.

Syphilis of the Larynx.

NOTES OF A CLINICAL LECTURE BY MR. STEWARD

Illustrated by lantern slides.

GENTLEMEN,—Syphilitic Affections of the Larynx are by no means common, for in ten thousand consecutive cases of throat disease examined by Mackenzie there were only three hundred and eight cases of laryngeal syphilis, or almost exactly 3 per cent. The disease is nevertheless an extremely important one, because it produces very grave results when untreated and also because its early recognition and treatment is followed in many cases by a satisfactory result.

Both sexes are affected by the disease and it may manifest itself at practically any age, because the larynx may be affected in both congenital and acquired syphilis. The great majority of cases are, however, the result of acquired syphilis and occur between the ages of twenty and fifty, but although this is so it is very important from a *practical* point of view to remember that *no* age is exempt. The changes that syphilis cause in the larynx are very numerous and may either belong to the secondary or tertiary stage. They may conveniently be arranged in the following forms:—

A. *Secondary*—
1. Laryngitis (Lewin's erythema).
2. Mucous patches and tubercles.

B. *Tertiary*—
3. Diffuse gummatous infiltration.
4. Localised gummata.
5. Ulcerations.
6. Cicatricial stenosis.
7. Perichondritis.

With regard to the question as to the period after infection that the various lesions are met with, it is *very important* to note that although the secondary manifestations *usually* occur within a year or so of infection yet they may appear only after a lapse of *many* years. The same applies also to the tertiary lesions. These usually occur several years after infection, but on the other hand they may appear within twelve months or even less.

I shall now say a few words about each of the conditions named in the list I have given you.

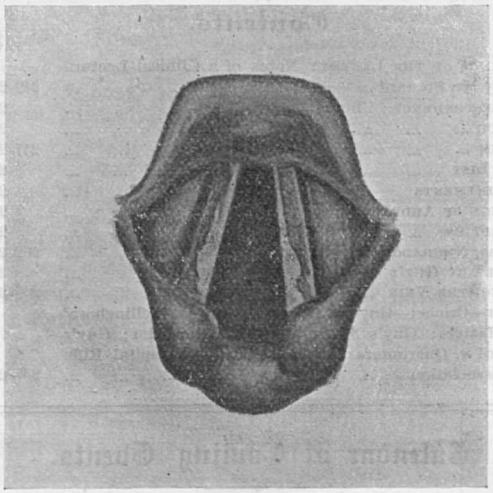
1. *Laryngitis*, or as it is sometimes called "Lewin's erythema," differs very little as regards appearances from ordinary simple catarrhal laryngitis. It usually occurs quite early in the secondary stage and is associated with cutaneous eruptions, glandular enlargements, mucous patches in the mouth and throat, and so forth. The patient is hoarse or even voiceless, and on examination the larynx is seen to be congested and the epiglottis and aryteno-epiglottidean folds perhaps a little swollen. It can only, in fact, be recognised as syphilitic in origin on account of the associated signs of syphilis, although it is said that the congestion is of a more dusky colour than in simple laryngitis. There is just *one* point which is well worthy of note in regard to this condition, and that is that it shows an *inveterate tendency to recur* over and over again, these recurrences sometimes extending over many years.

2. *Mucous patches and tubercles.*—These are extremely rare, but when they occur they differ as regards appearance in no way from mucous patches and tubercles as seen in other parts, that is to say, they consist of greyish or whitish patches more or less raised above the surface and surrounded by a congested ring.

I have only seen one case, a young woman with severe secondary syphilis who had a mucous patch situated on the posterior surface of the epiglottis.

Here is a drawing of a larynx showing mucous patches on the surface of each vocal cord (see Slide 1).

3. *Diffuse gummatous infiltration.*—This consists of a small-celled infiltration of the submucous tissue affecting parts, or in severe cases practically the whole of the larynx. The *symptoms* vary according to the seat and the degree of the infiltration; for instance, if the vocal cords are affected hoarseness will result, and if there is a general infiltration of the whole larynx, dyspnœa will be the chief symptom. These infiltrations may entirely resolve if recognised early and treated vigorously, but, on the other hand, the more frequent result is organisation of the infiltration leading to cicatricial stenosis, which may be very severe. These infiltrations also may break down and lead to ulceration, as I shall show later. It is *extremely* important to recognise this condition early and treat it vigorously because of the great tendency to production of cicatricial stenosis, which is a permanent and practically hopeless condition.



(Watson Williams.)

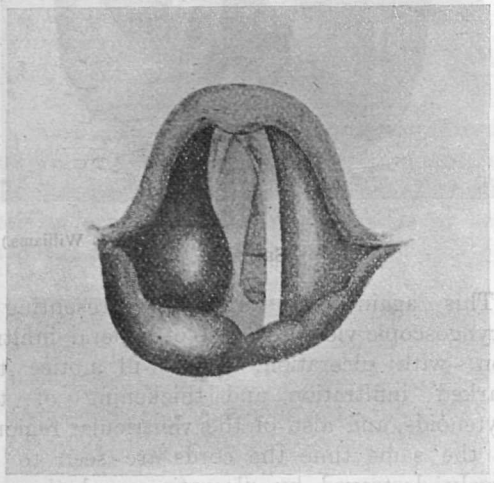
SLIDE 1.

The following case, which was under the care of Dr. Hale White, in Stephen ward, some years ago, is a good illustration of many points in connection with this condition.

A young man was admitted for severe dyspnœa, which had developed in about a month. He had had a hard chancre four or five years previously. On examining the larynx, the epiglottis, the arytenoids and the aryteno-epyglottidean folds were immensely thickened and infiltrated, so that the cords

could not be seen at all. The dyspnœa produced by this infiltration was so bad that it was thought that tracheotomy might be necessary at any moment, and for days the tracheotomy instruments were kept in readiness by the bedside. The patient was kept perfectly quiet in bed because any movement or exertion increased his dyspnœa at once, and he was given iodide of potassium in large and rapidly increasing doses, so that at the end of a week he was taking half a drachm three times a day. The result was extremely satisfactory, for he began to improve almost immediately, and at the end of a fortnight all his symptoms had disappeared and his larynx on examination appeared to be almost normal.

4. *Localised gummata.*—These are not nearly so common as the diffuse infiltrations, but they may form tumours of very considerable size.



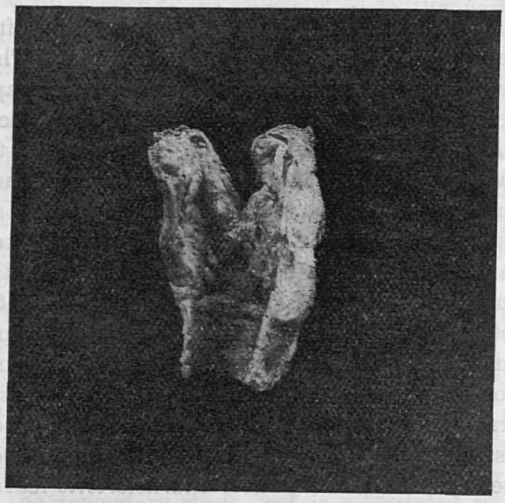
(Watson Williams.)

Slide 2.

This specimen shows a gumma of the right arytenoid. You will see that there is a smooth tumour of considerable size, and of a bright red colour. These gummata may occur practically anywhere in the larynx, but they usually originate in the submucous tissue, and they consist, as you know, of sharply circumscribed masses of small round-celled infiltration, or granulomata. They are usually surrounded by an area of considerable congestion and œdema, so that, as in the diffuse form, severe and often dangerous dyspnœa may be produced. They have a great tendency to sudden and rapid necrosis, with the formation of an ulcer which may extend deeply and involve the cartilage and cause its necrosis. These gummata, particularly when ulcerated, are often extremely difficult to diagnose from cancer, and I shall go more fully into this question when considering diagnosis. As the result of treatment healing is usually rapid, but there is a marked tendency to the formation of scar tissue. I would *most particularly* draw your attention to this formation of scar tissue, which contracts and leads to subsequent stenosis, for it is *the most characteristic* feature of laryngeal syphilis.

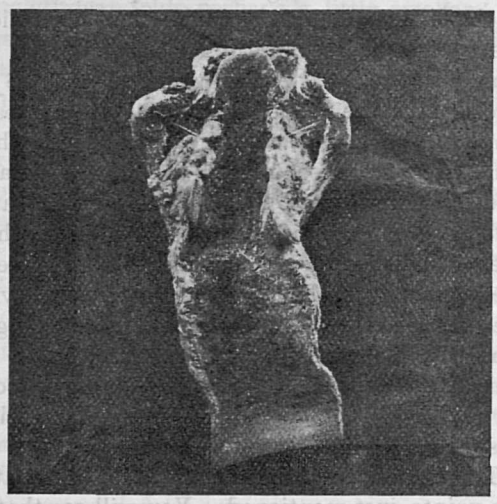
5. *Ulcerations.*—Ulceration of the larynx in syphilis is the result of the breaking down of gummatous infiltration whether of the diffuse or the circumscribed variety. It also may occur as the result of gummatous perichondritis. In the diffuse gummatous infiltrations ulceration has a tendency to spread superficially and to remain superficial. At the same time there is also always the tendency to heal at one part while further ulceration is going on at another part. The scars so formed evince, as I have already said, a great tendency to contract and deform the parts so that after the disease has been in progress for a considerable time very great changes in the appearances of the larynx are produced, and be it noted all these changes tend in the direction of the production of stenosis, and hence the predominant symptom in this condition is progressively increasing dyspnœa.

This specimen (Museum No. 49) illustrates the points just mentioned. You will see that it is a photograph of a larynx opened from the front. The true and false cords are gone, and their positions and also the posterior wall of the larynx show marked scarring and some ulceration. It is from a woman, æt. 30, who had aphonia and dyspnœa and was treated by Dr. Goodhart for some time for syphilitic ulceration of the pharynx and larynx. She died rather suddenly from laryngeal obstruction about a week after leaving the hospital (see Slide 3).



SLIDE 3.

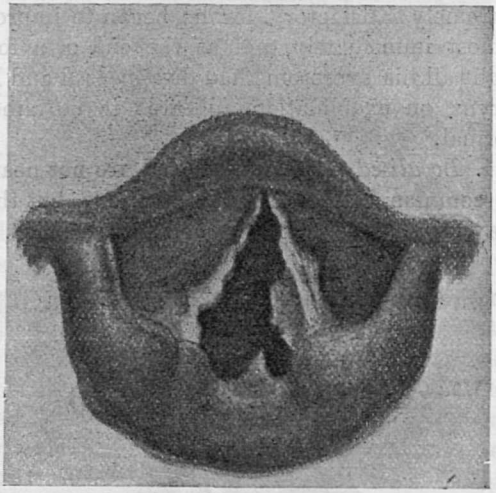
In some of these cases the ulceration is rapid and out of all proportion to the healing and scarring.



SLIDE 4.

The condition is well shown in this specimen (Museum No. 48) taken from a potman who had bad syphilis and died rather suddenly. You will see that there is wide spread ulceration of a superficial character extending from the epiglottis right down into the trachea. There is no sign of healing and of scar formation.

When ulceration takes place in a circumscribed gumma it differs from the type just mentioned in that deep excavated ulcers are formed as the result of the sloughing of the mass of gummatous material, just as those deep excavated ulcers on the dorsum of the tongue or of the testis accur as the result of the breaking down of a gumma. Such ulceration may extend deeply and so involve and destroy the perichondrium and thus cause necrosis of the cartilage.



(Watson Williams.)

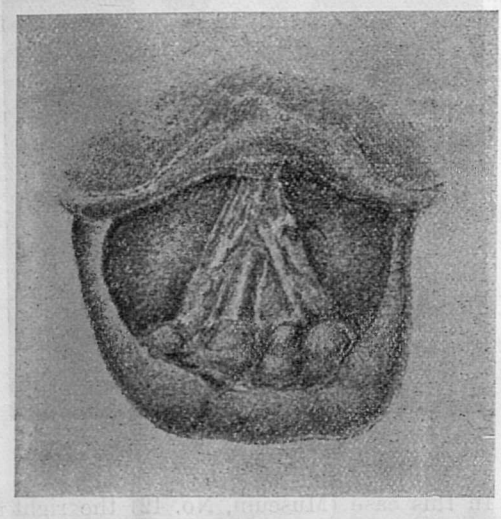
SLIDE 5.

This again is a drawing representing a laryngoscopic view in a case of general infiltration, with ulceration. You will notice the marked infiltration and thickening of the arytenoids, and also of the ventricular regions. At the same time the cords are seen to be largely destroyed by ulceration, and there is further ulceration on the posterior wall.

6. *Cicatricial stenosis.*--Narrowing or stenosis of the larynx may be brought about in *two distinct ways* as the result of syphilis.

In the first place, in a gummatous infiltration, organisation without ulceration may take place with the formation of fibrous tissue, which contracts, and in the second place scars which are the result of the healing of previous ulcerations contract, and so produce stenosis. In the majority of cases, however, both these processes

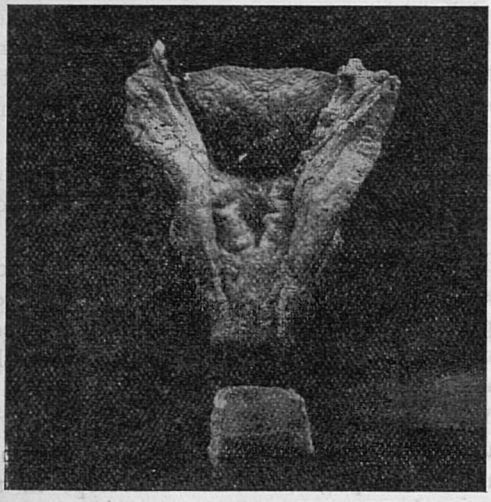
are in evidence, part of the scarring resulting from healed ulceration, and part from the direct organisation of gummatous material without ulceration. The appearances will, of course, vary according to the stage of the disease.



Watson Williams.)

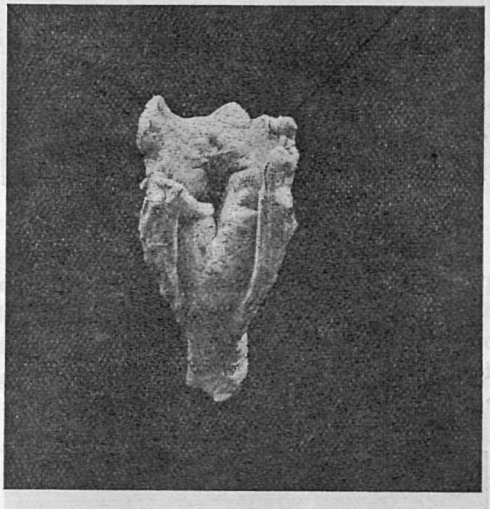
Slide 6.

In this case, for instance, ulceration is still going on in the posterior part of the larynx, while further forward you will see that the glottis is occupied by irregular bands of scar tissue, the result of past ulceration.



Slide 7.

In this specimen (Museum No. 47) you see altogether a later stage. There is no ulceration but the epiglottis has been completely destroyed by past ulceration and the whole upper aperture of the larynx is markedly puckered up and thickened from the formation of scar tissue. You can easily imagine what marked dyspnœa a condition such as this must have produced. It is from a man, æt. 24, who was admitted for dyspnœa, for which tracheotomy was performed.



Slide 8.

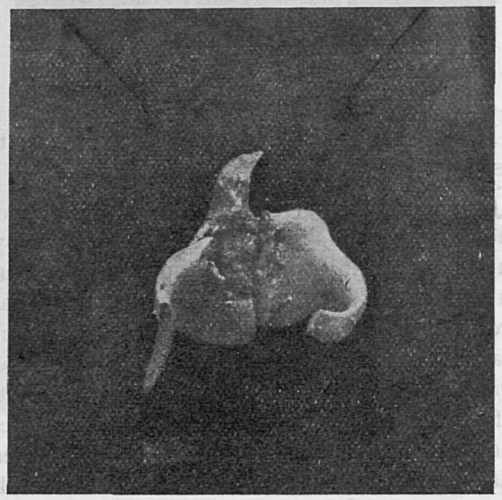
Here again is a very similar specimen to the last (Museum No. 45).

7. *Perichondritis.* — Syphilis produces perichondritis just as it produces periostitis, by a gummatous infiltration of the perichondrium. In some cases the infiltration organises and produces thickening and stenosis, just as gummatous periostitis of the tibia organises and produces an osseous node. In other cases the infiltration breaks down and leads to an ulcer, the floor of which is formed by the bare cartilage. Infection from the outside now takes place causing suppuration and death of the cartilage, and often the formation of abscesses of considerable size.

Here you will see that the perichondrium is separated from the cricoid cartilage by gummatous deposit, and on the right side the mucous membrane is ulcerated and the cartilage

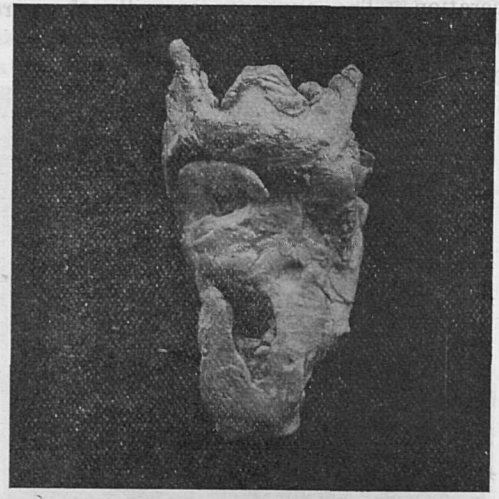
SLIDE 9.

exposed in the ulcer. The specimen (Museum, No. 46) is from a woman upon whom tracheotomy was performed for dyspnœa. At the autopsy gummata were found in the liver and lung.



SLIDE 10.

This slide (Museum, No. 43) shows a cricoid cartilage, a portion of which is necrosed and partially separated. It is from a man æt. 25, who had the scar of a former chancre and fibrosis of the testis. The cavity in which the dead cartilage lay contained three drachms of pus.



SLIDE 11.

In this case (Museum, No. 42) the right ala of the thyroid cartilage is seen to be necrosed. It lay in an abscess cavity which opened into the pharynx and also into the larynx. The specimen is from a man æt. 42, who had a venereal sore and a bubo four years before death.

There is one other result of perichondritis which it is important to note, and that is that perichondritis of the arytenoid frequently affects the crico-arytenoid joint. This subsequently leads to fixation of the joint with the result that the vocal cord attached to the affected arytenoid is rendered immobile.

Diagnosis.—I want now to touch upon some of the main points in the differential diagnosis of these conditions.

In the great majority of cases the diagnosis lies between three affections, viz., tubercle, syphilis and epithelioma, and these three conditions should always be considered together when dealing with a chronic laryngeal case.

With regard to *tubercle*, the diagnosis in many cases is extremely simple; for instance, when the laryngeal affection develops in the course of a case of well-marked phthisis. In other cases, however, the diagnosis is more

difficult, and then I think the following points will be found useful in arriving at a correct diagnosis.

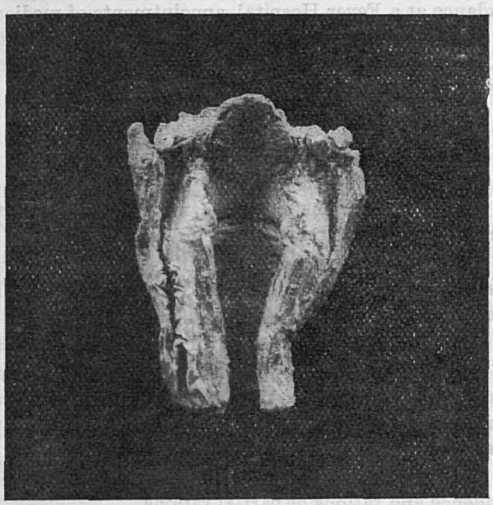
1. *Pain.*—Always severe in tubercle, slight or entirely absent in syphilis.

2. *Colour.*—Often marked pallor in tubercle, usually congestion in syphilis.

3. *Rapidity.*—Tubercle slow, syphilitic ulceration very rapid.

4. Tubercular ulcers small and numerous, syphilitic usually large and single.

5. Tubercular ulcers superficial, giving a worm-eaten appearance, syphilis deep and sharply limited.



SLIDE 12.

Here is a specimen showing extensive tuberculous ulceration The extensive superficial, worm-eaten appearance produced by numerous small ulcers shows very well. Note that there is no evidence of the scarring and deformity so characteristic of syphilis.

With regard to the diagnosis from epithelioma, the appearances may be very similar in both cases, especially where epithelioma shows itself in an infiltrating form. The following points, however, taken together, will generally lead to a correct diagnosis, although too great reliance must not be placed upon any one of them.

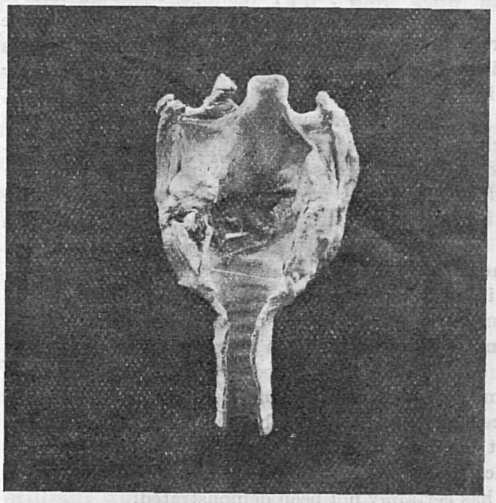
1. *Pain.*—Usually more marked in epithelioma, frequently entirely absent in syphilis.

2. *Early fixation of one vocal cord.*—This is strongly suggestive of the infiltration of epithelioma, especially if the infiltration is quite localized.

3. *Absence of all sign of cicatrization.*—This again, as you will have gathered from what I have already said, is greatly in favour of epithelioma.

4. *The administration of iodide of potassium.*—Although this may produce slight improvement in a case of epithelioma, the rapid disappearance of the infiltration in a syphilitic case makes this test perhaps the most important of all.

5. *Microscopical examination.*—In doubtful cases a small piece of the growth may be removed and a section cut. This is, however, best avoided if possible, as it is not unlikely to result in very rapid growth in epithelioma.



SLIDE 13.

Here is a specimen (Museum, No. 86) which shows a deep excavated ulcer with infiltrated margins caused by epithelioma. Note the complete absence of scar tissue.

Treatment.—I have only time to briefly mention one or two special points which are as follows:—

1. That in tertiary cases Mercury is extremely useful in addition to Iodide of Potassium.

2. Treatment will result in rapid improvement if the disease is in the *active* stage, but is unsatisfactory where scar tissue has already formed.

3. Tracheotomy will sometimes result in very considerable improvement where there is even marked stenosis, possibly owing to the rest given to the larynx, in the same way possibly as a Cock's operation will often lead to dilatation of the stricture in front of it.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Chorea.

DEAR SIR,—With your permission I should like to make an allusion to a paper recently published in the GAZETTE on the above subject. A good many cases occur in general practice—much more frequently probably than in hospital practice—of children suffering from slight choreiform movements. These cases cannot properly be described, as they sometimes are, as "exaggerated fidgets," because the movements are typically choreiform. There is no endocarditis, or other evidence of an infection, and with ordinary care they get quite well. They may be described as cases of chorea minor. One meets, both in hospital and in general practice, with cases in which the movements are more violent, and with sudden onset—following on fright or pressure during examination—and yet where there is no endocarditis. These cases used to be called "chorea without rheumatism." Of course it is not safe to conclude from the absence of endocarditis that these minor and major cases are not the result of infection; on the other hand, clinical evidence is very strong in this direction, and their microbic origin has certainly not been demonstrated.

Under these circumstances is it not better to take up, for the present, this attitude towards chorea? In a certain group of cases of microbic disease, endocarditis and choreiform movements are among the most constant pathological results; these cases are probably—as to causation—identical with or very nearly allied to, acute rheumatism, and had better no longer be called chorea. There is another group of cases in which choreiform movements are, up to the present time, practically the only discoverable morbid sign. For the present these cases might be called chorea major and minor, according to the violence of the movements. I do not consider that there is yet enough evidence to prove that we are not dealing with two distinct diseases: the one of extrinsic origin—due to an infection; the other of intrinsic origin—due to a function-failure originating in an unstable or overtaxed nervous system.—

Redhill. S. W. MACILWAINE.

Notice.

METROPOLITAN ASYLUMS BOARD.

ATTENDANCE AT FEVER HOSPITALS OF CANDIDATES FOR THE DIPLOMA IN PUBLIC HEALTH.

With a view, as far as possible, of enabling candidates for the Diploma in Public Health to comply with the regulations of the General Medical Council respecting attendance at a Fever Hospital, appointments of medical men as Clinical Assistants will be made from time to time, as circumstances permit, at the Board's Fever Hospitals.

CONDITIONS.

1. Candidates for the appointment of Clinical Assistant must be registered medical men.

2. Clinical Assistants will be in all respects subject to the regulations in force with regard to the Hospitals, in which they must reside.

3. The period of appointment will be three months.

4. The duties will be those generally allotted by the Medical Superintendent to the junior assistant medical officer of his hospital, and such other duties as he may determine.

5. The remuneration will be limited to the allowance of residence and rations or partial rations.

The following are the hospitals to which appointments will be made, viz:—

Eastern Hospital, The Grove, Homerton, N.E.
North-Eastern Hospital, St. Ann's Road, Tottenham, N.
North-Western Hospital, Lawn Road, Hampstead, N.W.
Western Hospital, Seagrave Road, Fulham, S.W.
South-Western Hospital, Landor Road, Stockwell, S.W.
Fountain Hospital, Grove Hospital, Tooting Grove, Tooting Graveney, S.W.
South-Eastern Hospital, Avonley Road, New Cross, S.E.
Park Hospital, Hither Green, S.E.
Brook Hospital, Shooters Hill, Woolwich.

All applications for appointment as Clinical Assistant must be addressed to the undersigned.

By Order,

Office of the Board, Embankment, E.C. (Corner of Carmelite Street).

T. DUNCOMBE MANN, Clerk to the Board.

Passim.

The Benefit Performance at His Majesty's will rank as one of the completest and most enjoyable artistic successes that has been yet recorded in the charitable efforts of our friends. In every way the result crowned the efforts that had been made, and a crowded and enthusiastic house enjoyed the evening whole heartedly and unreservedly. Rank and fashion assembled to support our Royal Patrons; wealth and beauty filled the seats, while the generosity of individuals secured for the representatives of the resident portion of the hospital a share in an evening that was at once unique and delightful. Everything went without a hitch and all were pleased.

The multifarious and complex arrangements consequent on the presence of the two Royal Parties were made with the skilled stage management that has always marked the festivities in which the Treasurer has been the ruling spirit. So attractive did the prospect prove that three days before the performance all seats had been sold and all complimentary tickets allotted, and there was not even an empty seat in the large house, and indeed some of the tickets had been returned and resold for the additional benefit of the hospital.

A generous Governor, whose name we are not at liberty to disclose, sent ten pounds for seats for the Resident Staff to Mr. Williams, who promptly secured them half-guinea seats just before they were all sold.

Actuated no less by the desire to be fair and to give equal pleasure, the same donor also placed ten pounds at the disposal of the Matron, but a serious difficulty had arisen, that all the seats, except those of fifteen shillings and upwards, had been disposed of. In this dilemma the Treasurer was approached, and though we are not allowed to state the name of the generous donor, sufficient was forthcoming to supply all the Sisters and practically all the Hospital Official Staff with higher priced seats. We wish that we were permitted to give him our heartiest personal thanks for a generosity that has been very generally appreciated.

In addition to these the rank and file had not been forgotten; yet again a Governor, conjointly with a senior member of our Staff, anxious for the general body of the nurses and the students, bought the entire gallery for their free use. Here again the Treasurer authorised the engagement of the entire pit, a small charge being made to the students to cover the increased cost, with the result that the 180 seats in the pit were allotted: 60 to Nurses, and 120 to Students and their friends. It had been suggested that the gallery should also be taken, but the time was short and the response not sufficiently quick, and it was therefore thrown open to the public, some of whom, with rare keenness, took up their stand outside nearly three hours before the time for opening. Of such stuff is the gallery "first-nighter" made.

The Matron had made arrangements for such nurses who were off-duty or could be spared, some sixty in number, to drive up in three enormous brakes, as the short time between their going off at 8 and the rising of the curtain at 8·45 made their chances of being in time somewhat precarious.

The crowd to see the arrivals began to assemble about 8 o'clock, and soon the entrance was thronged with journalists, aristocrats, and many well-known faces. It was impossible to follow all who were present or to describe the brilliant appearance that the house must have presented to the King.

The Royal Box was on the right, containing the King, the Queen, the Prince of Wales (in the last act), the Princess Victoria, and two in waiting, while Mr. Bonsor and Mr. Fripp, with the Poet Laureate and Mr. Tree, acted as cavaliers and received the Royal Parties and escorted them to their box. The Guy's portion of the house enjoyed this part of the performance greatly. Opposite the King, Lady Warwick brought a large party, consisting of her

daughter, her cousin, her sister (Lady Algernon Lennox), and Lady Eva Dugdale, the box presenting a most brilliant appearance in marked contrast to the more solemn dresses in the Royal Box.

The enjoyment of the evening to a very considerable extent lay in the presence of the King, the Queen, the Prince and Princess of Wales and Princess Victoria and their suites, who overflowed into the front rows of the stalls, where Mrs. Tree and Mr. and Mrs. Cosmo Bonsor also entertained parties. The Royal Box was the target of many glasses from the security of the dress circle and upper circle and pit. But "after all the play's the thing," and it was with varied feelings of anticipation that the audience awaited the arrival of the King and the rise of the curtain. It was generally felt the Laureate had had a difficult task in trying what Tennyson had failed to achieve.

The play may be considered from two points of view—as a literary product and as a drama. From a literary standpoint the first act is the best, though a little verbose and producing in many parts the unhappy effect of an echo of other poets. As a drama, the second act is fine, the situation splendid and exciting. Melodrama it escapes, and tragedy it distinctly achieves, but the furious speech was but tamely worded—there seems the weakness.

The prologue is mysterious, weird and somewhat unintelligible and uncanny. It is, however, based on tradition, and we suppose essential to the plot. The first Act gives an opportunity for admirable acting and a good song. The acting was splendid. Surrey pleased us much and James but little. Miss Constance Collier and Miss Miriam Clements were excellent, and without a warning of the tragedy to come the plot developed in interest.

Into the second act the whole action was crowded. Miss Collier played with equal skill the wanton, the snare, the wife, the exposée, and the dignified and splendid injured innocence, or rather outraged and insulted virtue. The story was rapidly unfolded. The grim note of tragedy was heralded by the arrival of the victorious general. Then followed swiftly and grimly, like some Greek play, amid deepening interest, the shock of the whole play, the dead body of the erst dallying King, the abandon and merciless triumph of the faithless woman, with the only possible end—the repudiation of her share in his glory, the horror of a man of honour at such foul treachery, his fury contrasting with her anguish, ending with the suicide of the scorned and outcast. It all went so quickly; for a few tense seconds one was thrilled with tragic deeds and words, and all was gone, leaving an impression of a great dramatic scene behind. The acting was splendid but the Surrey's return was not on a par with his earlier method, while Mr. Fred Terry—playing King James IV.—was beautiful and artistically complete. Miss Collier was splendid throughout and rose to every occasion.

"The Man Who Was," opened with a scene of such absolute beauty and brilliancy that the whole house rose at it and cheered loudly. The Mess Dinner of the White Hussars, marred perhaps by the presence of ladies in the correct but unsightly dress of the period, followed by the rest of the well-known Kipling story fairly faithfully followed, pleased all. Mr. Tree was "Limmason," an awful, tragic, and very pathetic part. It was played as only a master could play it. It held the house still, and it ranks as one of his finest efforts, reminding one of his earlier manner in "Trilby." It was followed with rapt attention, and loudly applauded at the close. It had blemishes; to our mind the introduction of the ladies was weak and unnecessary, and gave rise to an unnatural and inartistic delay at the finish. The simple, tragic episode, played by men alone, we believe would have been better. However, it is undoubtedly a very fine single-act play, and Mr. Beerbohm Tree's acting was grand.

In response to an enthusiastic demand, Mr. Tree made a characteristic and almost perfect little speech in which he said exactly the

right thing, thanked everyone concerned not forgetting the free services of the splendid company he had gathered together, and announced that the performance had produced the magnificent total of over two thousand pounds (£2,100), and that there were "no expenses," whereat the audience loudly cheered, and a brilliant assembly broke up. After the performance Mr. Tree entertained a large number of his friends at a Stage Supper, and the Treasurer thanked him and his Company and the innumerable workers who have done so much.

Among those present were, besides Their Most Gracious Majesties King Edward VII. (our former President and now our Patron) and Queen Alexandra, the President of Guy's H.R.H. George Prince of Wales, and T.R.H. the Princess of Wales and the Princess Victoria. Lady Warwick and a party were in the box opposite, and the Poet Laureate and his friends in the right hand box. Among many well-known fashionable play-goers were the Duke and Duchess of Portland, the Duke and Duchess of Wellington, the Duchess of Sutherland, and a considerable number of our Governors, including Lord Revelstoke, Lord Henry Bentinck, with the Countess of Bective and Mr. A. C. Cole.

The house presented a most brilliant spectacle, and the ranks of the nurses at the back of the hall excited general admiration and comment. The Queen appeared much interested. The gallery was crowded, and there were several standing up in the pit as well.

Friday, July 3rd, is the date fixed for the School gala day for the year, and the event must be looked upon as of even greater interest than usual in that it will include, not only the usual Distribution of Prizes, but also the ceremony of opening the Wills' Library.

The double function, we are glad to learn, is to be undertaken by Sir Frederick Wills himself, who, not content with taking great and continued interest in the Hospital and School, has now conferred upon us a real boon in the beautifully-fitted and carved library. We shall look forward to this opportunity of affording him a most cordial welcome.

The Library is one of the finest in London, and our School is truly fortunate in having provided for the use of its students such magnificent surroundings to read in. We can safely say that our appreciation will be shown by the good use which will be made of it by students both present and to come.

It is hardly necessary perhaps for us to suggest that we hope a large number of men will be present on the occasion to give Sir Frederick Wills a "Guy's" reception, and thus demonstrate to him our gratitude for his generous and munificent gift.

Prize Day and Garden Party will revert this year to the usual date and be once more a summer festivity Last year, owing to the Coronation and the Henriette Raphael Home, it was postponed to October. The same arrangements prevail, academic costume will be worn, and admission will be by ticket at the Maze Pond entrance till after the unveiling ceremony alluded to below, probably about 2.30 p.m.

All students have, or should have received invitation cards, but if there should be any who have not they can obtain them from the Medical School Office. It is hoped that as many as possible will wear academic dress, and that particularly there will be a large audience to show Sir Frederick Wills their gratitude for his generosity, and it is most important that all prize-winners without exception should appear in person to receive their rewards.

At the last meeting of the South African Memorial Committee, held in the committee room under the presidency of Dr. Frederick Taylor, at which the Treasurer was present, the following proposals were adopted:—To make the ceremony as simple and as dignified as possible, and to keep it entirely separate from any other function, and to also hold a short

service in the Chapel after the unveiling for those who wished; and to invite Sir Richard Harrison, K.C.B., K.C.M.G., Inspector-General of Fortifications, to perform the unveiling ceremony at 2.15 on Friday, July 3rd.

THE front gates will be closed and admission will be by the Maze Pond gates until the close of the proceedings at the Memorial, except those invited to the Memorial Service. Dr. Taylor will preside and will invite Sir Richard Harrison to unveil the Memorial. Sir Richard Harrison will give a short address and unveil the Memorial. The Treasurer will propose a vote of thanks to Sir Richard Harrison for coming down, and to Dr. Taylor, the Chairman of the Committee, for the labour and trouble he has expended. The Memorial will then be on view at the annual Prize giving.

THE fact that the Committee have been able to secure the presence of Sir Richard Harrison lends additional interest to the unveiling. Not only is Sir Richard by tradition and descent closely connected with King-Harrison, a redoubtable and famous bygone Treasurer, and so with us by family ties, but he is also a Governor whose attendances were for many years constant and most valuable. Since 1898 his duties as Inspector-General of Fortifications have taken so much of his time at the War Office that the Hospital has to a great extent lost his constant presence, but it is gratifying to learn that his interest is as deep and keen as ever, and that the approaching termination of his office leaves him as ready as ever to resume an active share in the duties of the Governors.

HE has had a distinguished military career, serving through the Crimea and Indian Mutiny, in Egypt and South Africa, and is therefore well qualified by experience to unveil the Memorial to the civilian surgeons from Guy's who fell. It is impossible in the circumstances to carry out a religious or military ceremony exclusively, and we think the proposed arrangements very happy.

IT is almost unique among memorials of the South African War hitherto erected in that it is on a purely secular site and not, as we believe all others are, on consecrated ground. That this is so is due to the wishes of the subscribers, who universally advocated an out-door memorial.

IT must be pointed out that the unveiling ceremony is not a public ceremony in the ordinary sense of the word, although there is no anxiety to keep it private. Invitations have been issued to the subscribers, the relatives and friends of the fallen, but of course, all the Guy's connection who desire to be present are welcome. The Committee would be very glad if all who can will aid them in letting it be widely known that friends and relatives of the fallen are welcome as it is impossible to be sure that invitations have been issued to all, and in the short space of time their addresses are very difficult to obtain. It is to be hoped all the students, nurses, sisters, and all who took any part in the war will make a point of being present, if possible, with their medals. Robes will probably be worn.

H.R.H. PRINCESS CHRISTIAN OF SCHLESWIG-HOLSTEIN has graciously consented to become President of Guy's Hospital Ladies' Association. This Association was started eight years ago with the primary object of providing clothes for necessitous patients. It has received such generous support that it is now able, in addition to this and other useful work, to maintain three beds in the Maternity ward by an annual donation of £150 from its funds. Mrs. Shaw, hon. secretary, 64, Harley Street, will be glad to hear of any who will assist in this excellent work.

THE Works Department is working with tremendous energy, as it is hoped to complete the arrangements in Hunt's House in time for Prize Day, July 3rd, though the necessary alterations take a long time, and it will also be found that Mary, after the years of activity within it, cannot be made fit for use in a very short time. Meantime the foundations of the improvements to the Office and the Job balcony, are being laid with commendable promptness.

DURING the unending stream of cases with undiagnosable complaints without physical signs or indications for treatment, the following letter was handed in from an old patient at out-patients. The wearied A. H. P. waded through it to discover the drift, a task we leave our readers.

Guys Hospital London
April 3 4 1903

Gnl Physician—Honourable Esq Sir

Its Quite A Compultion To Relieve My Mind Your Courteous Goodness Is Resolute Bravery Gallant Magnanimity Eminently Fulfiled To Appreciate To Value To Appraise To Admire In Preeminence Superiority Excellent In Dignity Your Greatness of Mind Is Valuable Administred Supreme Excellent Virtuous Good.

Significant of My Persevearences In Taking Your Valuable Medicine My Body Remains The Same No Change of Improvement No Vigour Renews Same Way Distressed

My Body In The Abdomen Feals So Lost For The Great Want Of Strength To Increase Power To Become Strengthtened. You Have Governed The Complaint With Your Abilitys From Increasing If Its Essential To Continue Rubing In The Ointment Morning And Night Your Abilitys May End Very Beneficial A Nother kind of Application May Improve My Body Your Benevolents Good Will Brings Great Consolation

Your Hble S^{t}

After short consideration he wrote briefly—

Rep. Ung. (21).

rightly as it turned out diagnosing satisfaction on the part of the recipient whose mental balance is not known to be disturbed.

THE Past cricket match takes place to-day and we fear the Past will have to look to their laurels if they wish to sit down to dinner with their blushing honours thick upon them. Mr. Brailey will, as in former years, entertain the two XI.'s and the Residents to dinner after the match, and as pleasant an evening as usual will probably result. It is to be hoped the weather by then will be more propitious.

MIDDLESEX HOSPITAL had been pursuing a triumphant career at cricket, defeating in turn St. Thomas's and ourselves, but it has unfortunately transpired that three of their XI. were not strictly eligible to play, and as a consequence a meeting was held to consider the point. The result is Middlesex have withdrawn and Guy's and Thomas's now meet to decide the entrance to the next round. May better luck attend them

Pass List.

Royal College of Surgeons of England, May. 1903.

FINAL FELLOWSHIP EXAMINATION.

J. Atkins, W. H. Bowen, P. W. L. Camps, F. E. Fremantle, W. G. Mumford, P. N. Blake Odgers, E. A. Peters.

PRIMARY FELLOWSHIP EXAMINATION.

L. H. Burnet. A. G. Jones.

Appointments.

CIVIL.

COPLANS, MYERS, M.B. Lond., has been appointed Resident Medical Officer to the North-West London Hospital, Kentish Town Road, N.

NAVAL.

Surgeon R. W. B. HALL, R.N., has been appointed to the *Bramble*.

Change of Address.

Fleet-Surgeon Everard Home Saunders, R.N., from the Royal Naval Barracks, Keyham, to the Royal Victoria Victualling Yard, Deptford.

Dr. T. E. Holmes' address is Rosendal, Redland Road, Bristol.

Dr. Reginald J. Roberts moves on the 24th instant from Gladsmuir Road to the Neuk, 71, Whitehall Park, N.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Novelties.

TRISCUIT.

This commodity is in the form of flat, oblong plates, about $4 \times 2\frac{1}{4}$ inches. No information is given by the makers as to its use, but we presume it is intended to replace the ordinary lunch biscuit. It is said to be baked by electricity, and appears to us as if made by soaking grain in water, then pressing through exceedingly fine holes, the shreds thus formed being pressed into cakes, and baked.

It seems like a whole-meal product, and on that account should be valuable. It is probably very nutritious. When boiled with water the shreds separate, and a little of the solution gave the reaction for starch with iodine; they cannot, therefore, be given to diabetic patients.

Facial Neuralgia.

A Paper read before the Dental Society, on Friday, March 6th, 1903, by Mr. HORACE CROAT, and was awarded the Society's Prize.

Mr. PRESIDENT AND GENTLEMEN.—The subject I have chosen for this evening, namely, Facial Neuralgia, is one that in my opinion is of paramount importance to the members of our profession, for I consider that dental trouble is the most frequent exciting cause of this distressing disease, which unfortunately has become more prevalent during the last fifty years. A fact that is no doubt due to our unnatural manner of living. The incessant rush, toil, and anxiety that modern civilisation demands, entails a great strain upon the nervous system as a whole, and so renders the nerve tissues less capable of performing their work in a proper manner. What would be but a slight local irritation in a person of normal vitality, becomes at once a severe diffuse pain in one whose powers of resistance have become lowered by our artificial life, crowded houses, and a hundred and one other sins that we daily perpetrate against nature's laws. The neurotic patient—a product of our boasted civilisation—you all know. These unfortunate people, who are usually excitable and irritable, and are in the habit of perpetually worrying over the smallest trifles, are very prone to neuralgia. A simple toothache becomes in them neuralgia of a severe form.

I fear that your knowledge of this disease will not be benefited to any great extent by anything that I may have to tell you; my intention is to read you a short paper, having a practical, rather than a theoretical bearing on the subject, and to confine myself more particularly to such cases as are likely to come under your hands for treatment. Of the pathology of neuralgia very little is known. Trousseau says that when a local pain gives rise to it, the spinal cord is influenced, and then through reflex action excites neuralgia. Dr. Anster, however, considers that the real seat is in the posterior roots of the nerves, and that the pain depends upon atrophy of a non-inflammatory character. This latter theory does not appear to be correct, for how would Dr. Anster account for the fact that neuralgia is often cured by the extraction of a tooth, if as he says, the essential cause is to be found in the posterior roots, unless, as Tomes suggests, it may be accounted for by the central change not being sufficient in itself to produce the pain after the cessation of the peripheral irritation. I notice that I have just spoken of neuralgia as a disease; this of course is not strictly correct, for it is not a disease, but merely a symptom of a lesion or morbid condition of the tissues which are supplied by this particular nerve, or by other nerves with which it communicates; but as it is usual to speak of it as such, I shall continue to do so.

First, then, what is meant by the term neuralgia? It is used to signify any pain which appears to shoot along the course of a nerve or its branches. The pain is almost invariably unilateral, and its onset quite sudden, but it may be preceded by some feeling of discomfort in that region. The paroxysms which are of a shooting, burning and boring character are short lived at first and the intervals quite free from pain, but at a later stage they become longer and more frequent, a dull aching remaining in the intervals, and as the disease wears on and the patient becomes more and more depressed so the agony suffered becomes more severe until life becomes a burden. In this condition the slightest irritant is capable of exciting an attack, such as a sudden noise, a current of air, or the muscular movements concerned in eating, laughing or blowing the nose. It is said that when neuralgia is due to the teeth the attacks usually occur in the evening, but when due to general causes, such as malaria, they are more prone to come on during the early part of the morning. The degree and duration may vary from a short lived paroxysm, which never returns to a disease of the most obstinate character which makes the patient's whole life a perfect misery.

There will usually be found one or more localizations from which the pain emanates. These spots are called the foci of pain, and seem to be characteristic of neuralgia. In the upper jaw the following are the usual sites: the infra-orbital foramen, the region of the malar bone and also along the whole alveolar ridge. In the inferior maxillary division of the fifth nerve we find the foci of pain situated in the temporal region, just in front of the ear and in the neighbourhood of the symphysis. But perhaps the most frequent focus of all is in the region of the parietal eminence. C. S. Tomes cites a case in which the act of touching an exposed pulp in an upper molar caused a severe paroxysm of pain in the parietal region although no pain was felt in the tooth itself. Neuralgia is undoubtedly rare in children, although it may occur in a mild form due to the delayed eruption of the permanent teeth. It most frequently manifests itself for the first time at puberty, and is then, should the subject be fairly healthy, most amenable to treatment. Young girls who at this period are often anæmic are especially liable to suffer. Anæmia itself will not produce neuralgia, but it brings about such a general diminution of resistance to morbid conditions that a slight irritation will produce most severe pain entirely out of all proportion to the cause. It is in patients who are middle aged and whose vitality has become depressed by general wear and tear, and may be disease and ill-health, that the most intractable cases are found; but in them neuralgia seldom occurs as a first attack, but usually as a revival of that which they suffered from at an earlier age. It should always be borne in mind that neuralgic patients are seldom in robust health, its appearance seems to depend to a great extent upon loss of tone due to conditions under which the patient is existing, such as bad sanitation, or living in houses built in a low damp district on a clay soil, this latter being particularly ill-fitted for people of a neuralgic temperament. Neuralgia is often brought on by cold damp weather, this is probably owing to the exposed situation of the fifth nerve, rendering it unduly

appreciative of atmospheric changes. But it seems as though there must be something else necessary, for otherwise in such a climate as ours neuralgia would be much more prevalent than it is.

Diabetes, malaria, influenza, rheumatism and gout may be numbered among the general diseases to which it is often secondary. In the later stages of diabetes, it frequently occurs in a very severe form, due perhaps to the great extent to which caries attacks the teeth of diabetics. That this is not the sole cause, however, is evidenced by the tendency to neuralgic pains, such as sciatica, that is exhibited by sufferers from this disease. Rheumatism as a predisposing cause is generally accepted, but Dr. Head throws much doubt upon this. He says that the fact that salicylic acid gives relief in certain cases, is no proof that the pain is of a rheumatic origin, for much benefit may be derived from the use of salicylates, where there is no evidence of rheumatism. Home troubles, business worries, overwork, and habits and pursuits that entail great excitement of the nervous system, also alcohol, through the degenerating effect that it has upon the nerve tissues, are strong factors to be reckoned with.

Hence the general line of treatment to be followed is very evident. Let the patient have as much freedom from worry and anxiety as possible, all depressing influences should be removed, and the general health improved by tonics, change of air, etc. It is of very great importance to treat the general condition and health of the patient, for whatever the cause of the pain, it is always aggravated by a general diseased state of the body.

Dr. Head, to whose researches we owe much, has classified the different forms of neuralgia as follows :—

First.—Neuralgia quinti major (tic-douloureux or epileptiform neuralgia). He considers that this is a definite disease of the nervous system, and that it has a distinct course and character.

Second.—Neuralgia secondary to disease of the nerves of the head, such as tumours involving the fifth nerve.

Third.—Neuralgia minor. This is the form that we as dental surgeons are most interested in. It may be due to (*a*) true visceral referred pain, due to disease of the internal structures of some organ of the head, (*b*) pains arising from disease of the membranes or tissues surrounding some organ, or to actual implication of the finer nerve twigs by the morbid process, and (*c*) neuralgia due to disease of organs other than those of the head.

Fourth.—The last group contains neuralgias arising from general bodily states, such as nervous exhaustion and hysteria.

Of the first, second and fourth groups I shall have little to say. It is with neuralgia minor that we have chiefly to contend, and so I purpose dealing, in this paper, almost exclusively with that form. Any morbid condition of the teeth or gums may act as the exciting cause, so when we examine the mouth, a very careful and thorough investigation is necessary lest it be overlooked. Dental neuralgia is most frequently set up by a localised chronic inflammation of the pulp accompanied by the formation of secondary dentine. In these cases the tooth itself often displays no abnormal sensation, but is quite free from pain ; indeed it might almost be laid down as a rule that a pulp that is causing acute odontalgia is not the cause of neuralgia. The usual history of an acute inflammation of the pulp, is that after causing severe agony for some hours, perhaps four or five, the pain suddenly ceases, the pulp having died through thrombosis and strangulation of its vessels at the apical foramen. But if a pulp, the subject of chronic inflammation be examined, it will usually be found to be healthy except at one spot, where will be a patch of chronically inflamed tissue of limited extent, and quite superficial. These cases of local inflammation usually occur when the exposure is so situated that irritating bodies, such as food, do not obtain ready access to it. It is this condition of affairs, when the cavities are so hidden and sheltered by their situation and approximal teeth, that so often occasions neuralgia, and for this reason, together with the fact that the tooth does not ache, the source of the trouble is often overlooked. In order to obviate any chance of this occurring, an invariable rule should be to pass a piece of silk up between each tooth and its neighbour, and should there be a cavity, the silk will show signs of abrasion. The thermal test should be applied, and also each tooth subjected to slight pressure, either by lightly tapping with an instrument, or allowing the patient to bite on something, such as a narrow strip of cardboard. Pain that is caused by an exposed pulp is usually worse when the patient is sitting over a fire, so that if you are told that this position gives relief the probability is that you will have to deal with periodontal trouble. A cause that is often overlooked is the absorption of the alveolus between two approximal teeth, which may be due to a badly contoured filling, or one with overhanging edges, allowing food to accumulate and set up a chronic localized inflammation of the periodontal membrane, which may lead to exposure of the cementum and thus irritation of the pulp. Of course there are numerous other causes, many of which I intend speaking of directly, some being easy of diagnosis, others, such as exostosis, being exceedingly difficult of discovery. The two that I have mentioned at greatest length, namely, localised chronic inflammation of the pulp and absorption of the alveolus are both fairly frequent, and I have chosen to speak of these first for the reason that they serve as good examples of the fact that through the difficulties presented the true cause is so often overlooked and both the dental surgeon and the physician come to the conclusion that the teeth are not the source of the trouble. This decision having been arrived at a tonic course of treatment is prescribed, and as the general health of the patient improves so may the neuralgia disappear, and everyone concerned is quite satisfied that the teeth had nothing whatever to do with the matter. But the neuralgia has not been cured, for so soon as the patient's health falls below par, so will the pain recur. Please do not think that I wish to imply that every case of facial neuralgia may be traced to the

teeth, that this is not so I am fully aware, for undoubtedly a very large percentage of them cannot be, but I contend that the fact that toothache is not present, that the pain is periodic and paroxysmal, and that a temporary cure may be obtained by the use of such drugs as quinine, is no proof that the teeth are not the cause. Unfortunately this sort of case is not at all uncommon, and hence there is a tendency among medical men to underrate the importance of the teeth as a frequent cause. Indeed so great an authority as Dr. Anster, probably through the inadequacy of the dental examination carried out on his patients, has been led to give it as his opinion that though the teeth may cause neuralgia even of a very severe form, and attended with extensive complications, yet looking to the extreme frequency of caries as compared with the rarity of neuralgia as a consequence of it, he felt that it was impossible not to suppose that the share of the carious teeth in the production of such neuralgia must be very small as compared with that of other influences.

In severe cases we find changes in the tissues of the affected district due to the normal blood supply being interfered with, a certain amount of vaso-motor paralysis having been provoked. Thus, in neuralgia of the second and third divisions of the fifth nerve, the corresponding side of the tongue may become coated with fur from overgrowth of the epithelium. This is not, as has sometimes been stated, due to that side of the mouth not being used in mastication owing to the teeth being painful, for as it occurs when they are not affected at all, it is evidently due to alterations in the nutritive supply. We find changes of a somewhat similar character in other parts. Thus it is not uncommon for hairs in the neighbourhood of the affected nerve to hypertrophy, or maybe the converse happens and they atrophy become brittle and fall out. Changes in the colour often takes place and small blanched patches appear at the seat of pain, which may return to their normal hue on the subsidence of the attack, or may remain permanently whitened. The skin is also liable to become coarse and pigmented, or crops of herpes appear leaving cicatrices somewhat resembling small-pox. All sensation of touch is sometimes lost, but more frequently the skin becomes exceedingly tender, indeed the hyperæsthesia may be so great that to have the face washed, the hair combed, or even wear a hat becomes almost unbearable. Reference to the hypersensitiveness of the skin brings me to some very interesting researches of Dr. Head. He says that when an organ such as an eye or a tooth is affected, pain is not confined to that organ itself but is referred to parts at a distance on the scalp or face, and that the part to which the pain is referred becomes tender and hyperæsthetic. Thus a morbid condition of the upper incisors would produce pain and tenderness in the skin of the nose and forehead just to one side of the median line. Morbid conditions of certain viscera affect definite regions, and so following out this theory, Dr. Head claims that from the skin area that is affected with hyperæsthesia the tooth or teeth at fault may be discovered. If this be so it should be of great help to us, but unfortunately these ligamental areas (as he calls them) although they appear to be fairly accurate in other parts of the body, are not to be relied upon when applied to the head. The theory brought forward to account for this phenomena that I have just mentioned is, that painful impressions may be conducted up the sensory fibres of the sympathetic into the central nervous system, and then referred to the peripheral distribution on the surface of the body of those nerves that enter the same segment.

These segmental areas of referred visceral pain have been mapped out by Dr. Head somewhat as follows:—When superficial tenderness is found in the region of the upper lip and alæ of the nose, the canine and first premolar are at fault. Pain referred from the second premolar or first molar affects the cheek and temporal region. That from the second and third molars the inaudibular area over the ascending ramus but pain may be referred from the wisdoms to the superficial parts just beneath the lower jaw.

In the mandible, the incisors, canines, and bicuspids produce tenderness in the mental region. The first and second molars affect the hyoid area, which is just beneath the lower jaw. Lastly the lower wisdom produces hypersensitiveness in the superior laryngeal and hyoid region.

These areas have not as yet been fully tested, and indeed, do not appear to be entirely reliable; for instance, it is a matter of common knowledge to us all that a lower wisdom will frequently cause pain in the mental region, but according to Dr. Head it should be confined to the superior laryngeal and hyoid district. This apparent discrepancy may, however, be due to the fact that the pain complained of in the mental region, when the wisdom is at fault, may not be of a referred character at all, but rather one of the "points douloureux," or foci of pain that Valleix speaks of. There is much confusion made between Dr. Head's "segmental areas," and Valleix's "foci of pain." C. S. Tomes himself seems to be rather sceptical of Head's statements, because his sensitive spots do not agree with those given by Valleix. As far as I can see, there is no reason why they should agree, for as a matter of fact they have nothing whatever to do with each other, for while the hyperæathesia experienced in the "segmental areas" of Head is of a true referred character, that found in the "foci of pain" is of quite a different nature. For in the latter case, the pain occurs either where the nerve emerges from its bony foramina, or where it pierces the deep fascia, the tenderness being produced by the nerve being surrounded by tissues of a denser character than elsewhere, thus being more susceptible to pressure. In testing for these segmental areas, the usual procedure is to pass the head of a pin lightly over the skin, and when the tender region is approached it will feel to the patient (as Mr. Hopson puts it) as though you were using the business end of the pin. The hypersensitive area on the scalp may be discovered by lightly pulling the hair. As I have already said, too much reliance must not be placed in this theory

which I have just mentioned, but there are, however, certain situations in which pain occurs, that have long been recognised as indicative of the point of lesion. Thus pain referred to the ear or temporo-maxillary articulations is almost diagnostic of a morbid condition of one of the lower molars. Any tooth in the upper jaw may cause pain in the orbit, but when the pain is most severe on the side of the head or upper part of the temple, the source of the trouble will usually be found towards the back part of the superior maxillary.

According to Dr. Head, so long as the pulp is not exposed, the pain remains local, although it may dart and shoot, the darting and shooting remain practically confined to the aching tooth, but as soon as the pulp is exposed the pain alters in character and distribution, becoming in fact neuralgia. This definition which thus prohibits an unexposed pulp from causing neuralgia will not, I think, be accepted by the majority of dental surgeons. Cases are not infrequently recorded where the formation of secondary dentine has given rise to severe neuralgia although there is not and never has been any actual exposure of the pulp. The following illustrates this to a marked degree, and was recorded in the Transactions of the Odontological Society a year or two ago. The patient was a man of about forty-five years of age, having teeth quite free from caries but showing marked attrition; in fact in many of them the pulp would have been exposed had it not been prevented by the formation of secondary dentine. As no other cause could be discovered it was thought that perhaps this secondary dentine might be the source of the neuralgia, and as a last resource all the teeth were extracted with the result that the pain entirely disappeared. You may say, "Why were the teeth extracted? Why not remove the pulp instead? For if irritation of the pulp were the cause surely the most rational thing to do would be to remove the pulp and and not the tooth." But it must be remembered that it is in these cases where the secondary formation of dentine has gone on to such an extent that the pulp cavity is almost, but not quite, obliterated, that the greatest difficulty is experienced, for arsenic has very little effect on a pulp in this condition and it is useless to attempt its removal under an anæsthetic as the operation would be too long and tedious. Although there is now doubt that conservative treatment should be carried out whenever possible, yet I do not consider it wise to attempt to save a tooth that is causing severe neuralgia unless it can be done both with little pain and little delay to the patient who is already worn out and depressed by the suffering already endured, and whose only wish is to obtain relief as quickly as possible. It is a very common occurrence to find the pain caused by a carious tooth referred to a perfectly innocent one on the same side, in either the upper or the lower jaw, but it is never referred across the median line of the mouth. This condition may be so pronounced that if the offending tooth be touched a severe paroxysm will be felt in the sound one. Sometimes the extraction of a tooth is followed by severe pain which may recur at intervals for some days. Relief may be given in these cases by mopping out the sockets with phenol, or allowing a small crystal of zinc chloride to remain in the bottom. Perhaps a safer and pleasanter method is to apply a dressing of oil of cloves and cocaine. It is always well to warn neuralgic patients of the possibility of this happening, otherwise it is not unlikely that the patient finding that the pain has been in no wise alleviated, but is perhaps worse, will ascribe the whole trouble to you. "The man in the street" is such an unreasonable being.

Wedl considers that this post-extraction pain is due to the ends of the severed nerve becoming enlarged and painful, as often occurs after an amputation. To obviate any possibility of this, Dobbelin drills into the pulp chambers of all the teeth, whether they be carious or not, and removes the pulp. By this means he claims to have effected a complete cure of a case for which the infra-orbital nerve had been already removed without any benefit.

About twelve months ago we had a very interesting case in the conservation room. The patient was a stout rather alcoholic-looking man of about fifty years of age. He complained of having suffered from severe pain on the left side of his face for the last two years. The attacks always commenced in the region of the former site of the lower wisdom, and from thence the pain travelled forwards to the symptahysis. So sudden and severe was the onset of the paroxysms that he sometimes fell to the ground. Before presenting himself here he had been under observation at another hospital for three months, but they had been unable to do anything to alleviate his suffering. On examination it was found that all the teeth from the canine backwards, on the affected side, had been removed, and that the gum over the wisdom area was slightly inflamed. As we could ascribe no other cause to the neuralgia, we thought that it might possibly be due to a buried root, although nothing could be felt with a probe. An examination under an anæsthetic, however, proved that there was no root there. Unfortunately I am unable to tell you what subsequently became of the patient for he vanished, which is a little way hospital patients have.

I have mentioned this case because it seems to have many points in common with the peculiar form of neuralgia described by Dr. Gross as occurring in edentulous jaws or in spaces whence teeth have been removed. He considers that it is due to the minute nerves distributed throughout the alveolar border having become compressed by the deposition of osseous matter in the canals. Some support is lent to this theory by the bone having been found to be abnormally dense when cut down upon at the affected spot. Another cause that is easily overlooked is a buried root which has become covered with healthy gum, and then subsequently given rise to irritation. Its presence may be detected by passing a sharp probe into the edentulous gum, the bone being easily penetrable to a small distance, but a root not being so the probe will be felt to strike something hard. Sometimes, however, a root will become softened to such

an extent as to allow an instrument to pierce it, but in these cases the probability is that the gum will not be in a healthy condition, so that the test is quite reliable.

In conclusion, let me add a few more words concerning treatment. I will not deal with that which is purely dental, for besides being unnecessary it would occupy too much time.

Of the drugs that may be administered internally, the antipyrin group are extremely useful. Phenacetin, the mildest of these, in doses of ten to fifteen grains, will often give complete temporary relief. Gelsemium and butyl chloral are also of great use, especially in cases where the antipyrin group are not very effective.

As a local application nothing is so good as a small blister or a leech or two applied to the seat of maximum pain. A paint of equal parts of camphor and chloral rubbed up together will sometimes give relief. Dr. Head strongly recommends the use of ethyl chloride spray, after first protecting the skin with a layer of grease. Galvanism is also very useful, the anode should be applied over the painful spot and the kathode over the spine. During the last few years treatment by surgical means has been introduced. The simplest form of operation is that of cutting down upon the nerve and stretching it. If this fails the nerve may be severed, or a piece removed. Unfortunately, however, only temporary relief is usually obtained by these means, the pain returning within a year or two, owing to the severed ends of the nerve reuniting. But there is always the chance that by the time continuity is restored the health of the patient may have so improved that the pain will not recur.

When all else has failed more severe operations, such as removal of the gasserian or otic ganglia, are undertaken. Although this always gives relief, it is never practised save as a last resource, owing to the severity of the operation, and the sensory and trophic changes that ensue. Lastly, I would mention that many cases have been very successfully treated by hypnotism.

Gentlemen, I feel that an apology is due to you for the superficial manner in which I have treated this subject, but so little is really known about neuralgia, and it arises from so many causes, and assumes such varied forms, that it is impossible to deal at all exhaustively with it in such a short paper, and as I have already exceeded the limits that I originally determined upon, all that remains for me to do is to thank you most sincerely for the very patient audience you have given me.

Papers by Guy's Men.

Gynæcology in General Practice. By Thomas G. Stevens, M.D., F.R.C.S., M.R.C.P.—*Clinical Journal*, 17th June.

On Some Affections of the Hip. By A. H. Tubby, M.S., F.R.C.S., Lecture I.—On Tubercular Disease of the Hip Joint.—*Ibid*, 10th June.

In Lighter Vein.

STAFF WALK TO THE ELEPHANT.

FIRED by the noble example of the Stock Exchange, the B.T.T., and other public bodies, the Staff of Guy's Hospital decided on a walking race to the Elephant and Castle. Great excitement was caused by the announcement of the race, and additional zest was given by the rumour that a match had been arranged between Dr. Perry and Mr. Brydone on unpaced motors to St. George's Church. In order to get the best posssible account for our readers, we arranged for a number of reporters at each stage, while one accompanied the race throughout on a stretcher.

GUY'S HOSPITAL.—A huge crowd had collected to see the start, necessitating repeated charges by the police. The competitors got away in a bunch, but at the statue Mr. Steward, who was paced by Master Frankie, was leading. Mr. Lane was last off the mark and paused to say a few words on the meteorological outlook. Mr. Jacobson said nothing. Dr. Pitt, accompanied by Mr. Wrench, followed the walkers in order to investigate the vexed question of their leucocytosis. When the last competitor had been shown out, the motor bicycle race started. The betting was long odds on Mr. Brydone, who had shewn splendid form on two chairs. He told our reporter that he felt confident of victory if he could once get the thing to start. He explained exactly how the machine should be worked and the fallacies likely to baffle anyone but an expert. He then got off the chairs and pushed off.

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After he had been dressed he pluckily decided to try again. He explained that the reason why he had fallen off was simply this: He was using stale petrol, besides, the advance sparking had backfired, a most unusual thing. He then pushed off again.

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On recovering consciousness, his first words were for the dog. He then decided to finish the rest of the race on two chairs. Meanwhile, Dr. Perry had been busily engaged filling his machine with ointments, which he explained were less active than petrol. He had some difficulty in starting owing to mistaking the bicycle for a pianola. He lit a match to look for the music and blew up the whole show.

St. Thomas's Street.—All the competitors were well up but Mr. Jacobson was leading by a head. Mr. Lane was so pleased with that bit of the walk that he said he would walk it over again in case anyone had not followed him. At the corner of the street, Mr. Tommy Hicks was disqualified, much to the amusement of Mr. Fagge, for running. He protested and said he had to run to keep up with the grown-ups. Mr. Lucas and Mr. Symonds were going well.

St. George's Church.—Mr. Jacobson was leading by his front canvas. Mr. Lucas was second, but here gave up owing to straining his supinator longus. Mr. Lane brought up the rear and asked our representative if he had seen his house surgeon. He seemed to be delighted with the weather. Mr. French gave up, as he lost his hat. Mr. Turner confided to our reporter that the hat was not really lost but was being redecorated and enlarged.

Elephant and Castle.—A huge crowd had assembled to see the finish. Mr. Jacobson was as befits the President of the football club, an easy first, but resisted all attempts at interview. Mr. Symonds next arrived (in a tramcar). He said it had been a most illuminating walk and he only remembered three hundred and nine similar cases. It was a most remarkable walk. Mr. Fagge came next. He was very pleased and offered to politzerise our reporter for nothing. Mr. Lane came in last and said he was dreadfully tired of this sort of thing: the weather was so trying. He then told our reporter the sad news that Mr. Tommy Hicks had been disqualified. Mr. Golding Bird looked in at the end just to see if any mistakes had been made. He congratulated the winner and left.

VERTIGO.

Sport.

Cricket.

GUY'S v. HORNSEY.

This match was played at Honor Oak on Saturday, June 6th, and ending in a victory for our opponents. Our reverse on the preceding day seemed to leave an appreciable effect on our men, little interest being taken in the game, Bookless and O'Brien alone offering any resistance.

Hornsey.

S. L. Clarke, b Morgan	24
T. L. Tate, not out	101
S. L. King, b Morgan	15
A. T. Tuberville, st Louisson, b Wyatt	1
F. H. Swinster, st Louisson, b Wyatt	4
H. B. Corry, c O'Brien, b Davies	23
J. H. Nicholls, lbw, b O'Brien	35
S. M. Banker, b Davies	11
M. Lewis, b Davies	1
A. S. Flower, b Davies	0
W. Kenny, b Morgan	3
Extras	6
Total	224

Guy's.

F. Morres, c Lewis, b Swinster	1
H. D. Wyatt, c Banker, b Clarke	8
J. S. Bookless, c Clarke, b Tate	36
A. B. O'Brien, b King	38
H. M. Langdale, c Tuberville, b Clarke	0
R. Willan, c Clarke, b Tate	0
E. Morgan, b Tate	1
L. G. Davies, c Tuberville, b Clarke	24
E. A. Collins, c Tuberville, b Tate	14
M. G. Louisson, b Tate	0
C. M. L. Cowper, not out	0
Extras	24
Total	145

GUY'S v. WELLINGBORO' MASTERS.

This match was played at Wellingborough, on Saturday, June 13th. Owing to rain, only an hour and a half's play was possible after lunch, in which time we scored 136 for 7 wickets. Score:—

Guy's.

F. Morres, c Bird, b Fryer	35
H. D. Wyatt, c Manning, b Edwards	1
H. M. Langdale, b Simpson	0
R. Willan, b Edwards	20
E. Morgan, c & b Fryer	2
E. A. Collins, not out	29
E. L. Morton, c Bird, b Edwards	19
M. G. Louisson, b Edwards	7
Extras	24
Total (for 7 wickets)	136

L. G. Davies, G. N. Bartlett, S. A. Piper did not bat.

Wellingboro' Masters.

P. A. Fryer, Bird, Edwards, Manning, Dyson, Simpson, Mainprice, and four others.

GUY'S 3RD v. MERCERS' SCHOOL 1ST.

This match was played at Wandsworth on Friday, June 5th, and ended in an easy victory for the hospital by 87 runs. Bartlett played a good innings of 47. Rice took 3 wickets for 3 runs. Scores :—

MERCERS' SCHOOL.

Browett, c & b Young	3
Tilly, c & b Young	1
Evans, run out	5
Bell, b Leeming	28
McCallum, c Brookhouse, b Bartlett	10
Mayer, b Leeming	4
McCallum, b Rice	0
Dowsing, b Rice	0
Williams, lbw b Rice	0
Allen, not out	4
Jones, did not bat	0
Extras	9
Total	64

GUY'S.

A. Leeming. b Dowsing	7
A. D. Vernon Taylor, b Bell	19
H. G. Gibson, c Dowsing, b Evans	3
G. N. Bartlett, c Dowsing, b Tilly	47
T. R. Harvey, b Bell	5
G. F. Young, c McCallum, b Bell	10
G. E. Rice, c Williams, b Bell	24
H. O. Brookhouse, b Mayer	11
D. Reynolds, c Bell, b Mayer	16
A. L. Gardiner, not out	4
H. N. Eccles, st Browell, b Mayer	0
Extras	5
Total	151

GUY'S 3RD v. QUERNMORE SCHOOL 1ST.

This match was played at Bromley on Saturday, June 6th. After a good and exciting game, the Hospital won by 4 runs. Rice took 5 wickets for 8 runs.

GUY'S.

H. H. Moyle, run out	14
A. D. Vernon Taylor, b Patrickson	2
T. R. Harvey, b Patrickson	11
G. E. Rice, c Carpenter, b Patrickson	12
R. G. Yates, b Tucker	1
H. O. Brookhouse, st Zimmerman, b Patrickson	2
H. R. Bastard, c Patrickson, b Carpenter	1
C. H. Mills, b Patrickson	9
W. Greening, lbw, b Patrickson	0
H. N. Eccles, b Patrickson	5
A Sub, not out	1
Extras	35
Total	95

QUERNMORE SCHOOL.

Zimmerman, b Rice	41
Green, b Moyle	0
Tucker, b Moyle	10
Davies (II.), b Greening	4
Patrickson, b Rice	0
Carpenter, b Mills	6
Scherider, c Brookhouse, b Rice	4
Scott (I.), b Greening	0
Jepson (II.), c & b Rice	2
Jepson (I.), b Rice	11
Lewis, not out	2
Extras	11
Total	91

Guy's Hospital Rifle Association.

ARMITAGE CUP.

Second Shoot, Runnemede, 27th May, 1903.

GUY'S.

J. S. Cooper	84
G. C. F. Robinson	80
G. A. Ticehurst	79
R. Felton	71
F. B. Lowe	62
L. L. C. Reynolds	52
TOTAL	428
St. Bart.'s	476
St. Thomas's	441

Births.

PENDRED.—On June 16th, at King's Wear, Loughton, Essex, to Berthon F. Pendred, M.R.C.S., L.R.C.P. Lond., and Eleanor Pendred, a son.

STEWARD.—On June 14th, the wife of F. J. Steward, M.S., of 133, Harley Street, W., of a son.

Marriages.

HICKS—PARLBY.—On the 4th June, at the Parish Church, Harold Wood, Buller Hicks, of Easingwold, Yorkshire, to Maud Parlby, second daughter of Col. Parlby, of Walsingham, Harold Wood.

KENDAL—GODSON.—On June 10th, at St. Mary's Church, Cheadle, Cheshire, by the Rev. John Godson, M.A. (uncle of the bride), assisted by the Rev. A. R. Goodacre, M.A., and the Rev. F. A. Macdona, M.A., (Rector of Cheadle), Herbert Mowle, eldest son of Thomas Herbert Kendal, Gatley Hill, Cheadle, Cheshire, to Dorothy Jane, second daughter of Alfred Godson, M.B., of Cheadle, Cheshire.

WARD—COCK.—On June 10th, by special licence, Percy H. Ward, M.R.C.S., L.R.C.P. Lond., M.O. Ayrshire Gold Mine, Limongunda, S. Africa, son of Colonel Harry Ward, The Grove, Derby, to Hylda Reynolds, only daughter of Dr. and Mrs. Cock, 147, Queen's Road, S.E.

ED.—J. M. B.

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Calendar of Coming Events.

July, 1903.

Sat. 4.—Messrs. Golding Bird and Dunn's take-in; Drs., J. M. Barrionuevo and F. Barnes; Cl., A. R. Brailey.
G.H.C.C., I., v. Heath Asylum C.C., 11 a.m., Bexley.
II., v. St. Bart. s, 2 p.m., Winchmore Hill.
III., v. Hos.-Scho., 2 p.m., home.
G.H.L.T.C., I., v. Brixton Wanderers, home.

Mon. 6.—1.15 p.m., Clinical lecture by Mr. Brailey.
Intermediate M.B. Lond. Exam. begins.
First part of Conjoint D.P.H. Exam. begins.

Tues. 7.—Final Conjoint Exam. begins.
Applications to Medical School Office for Schedules for 1st Conjoint Exam. to be made not later than this date.

Wed. 8.—1.30 p.m., Clinical lecture by Dr. Bryant.
August Appointment List closed.
G.H.C.C., I., v. Mr. Laycock's XI., 11 a.m., Bawtry, Notts.
G.H.C.C., II., v. Thespids, 11.30 a.m., home.
G.H.C.C., I., v. Gravesend, 2.30 p.m. Gravesend

Thur. 9.—Mr. Jacobson and Sir A. D. Fripp's take-in; Drs., J. H. Clatworthy and J. M. F. Pollard; Cl., F. W. Fawssett.

Fri. 10.—1.15 p.m., Clinical lecture by Mr. Steward.

Sat. 11.—G.H.C.C., I., v. Addiscombe, 2.30 p.m., home.
II., v. Old Olavians, 2 p.m., away.
III., v. New Eltham, 2 p.m., Eltham.
G.H.L.T.C., I., v. Surbiton "A," Surbiton.

Mon. 13.—Second part of the Conjoint D.P.H. Exam begins.

Wed. 15.—1.30 p.m., Clinical lecture by Dr. Bryant.
G.H.C.C., I., v. Eltham, 11 a.m., Eltham.
II., v. Manor House School, home.
G.H.L.T.C., I., v. Harold, Gipsy Hill.

Thur. 16.—Messrs. Symonds and Steward's take-in; Drs., J. E. Prentis and W. N. May; Cl., L. S. H. Glanville.

Fri. 17.—1.15 p.m., Clinical lecture by Mr. Steward.

Sat. 18.—G.H.C.C., I., v. Streatham, 11 a.m.,
III., v. Quernmore School "A," Bromley.
G.H.L.T.C., I., v. Boundaries, home.

Guy's Hospital Gazette,

JULY 4, 1903.

Ascites: the Diagnosis of its Cause, and its Treatment.

CLINICAL LECTURE BY DR. L. E. SHAW.
June 10th, 1903.

GENTLEMEN,—A few days ago there died in Clinical ward a young woman whose main symptom was Ascites. She came in a year ago when I was last taking charge of the ward. We were unable then to determine the cause of her ascites, and we are still unable to do so though she has been submitted to two laparotomies and one complete post-mortem examination. The physicians, surgeons and morbid anatomists have all failed to determine the exact cause of her ascites. We are now waiting for the report of the histologist to clear up the problem with an amount of confidence which I think is in inverse ratio to our ages. There is another patient lying in the ward with ascites who has been tapped six times in the last twelve months. She has, therefore, as you can imagine, been under the observation of many physicians. She presents so many pathological lesions, any one of which might be the ultimate cause of her ascites, that there are still many opinions held about the nature of her disease. These two cases led me to reflect how difficult it sometimes is to tell what is the cause of ascites, even though we are quite confident as to its existence. And when we do not know what is the exact cause, we are naturally a little uncertain as to what view we must take of the prognosis of the case, and our treatment is

carried out with some want of confidence. I therefore thought an appropriate subject for the lecture to-day would be Ascites: an Introduction to the Diagnosis of its Cause, and its Treatment. You will see that I do not propose to deal with the question of the diagnosis of the existence of ascites, not because I want you to believe that the diagnosis of its existence is not difficult, very often it is extremely difficult. It is often difficult and very important for you to be able to diagnose between ascites and an ovarian cyst. It is less important, though often quite as difficult, to diagnose between ascites and colloid disease of the peritoneum. Those of you who attend out-patients regularly will surely before long see cases presenting difficulties as to the diagnosis between ascites and obesity. I am merely leaving out the question of the diagnosis of the existence of ascites so that I may have time to deal with the diagnosis of its cause.

The number of individual diseases which might give rise to ascites is so great that if I took them *seriatim* and pointed out the various features by which you may reach a differential diagnosis, I think I should only make confusion worse confounded. For the purpose we have in hand the causes of ascites may be roughly divided into three groups. A little squeezing will be necessary to get all the cases into these three groups, and a little overlapping will be inevitable. That is always the case when we try to make definite this very undefined science of medicine. But if you can, in some rough way, get the causes grouped into three divisions, you will generally be able to place an individual case in one of these groups. And having so placed it, you will at least have less possibilities to consider; and even if you cannot get at the exact truth in the matter, you will perhaps be near enough to enable you to express an opinion as to the ultimate result, and will be able to treat your patient with some degree of confidence. These are the three groups I want you to become familiar with: (1) Ascites may be part of a general dropsy; (2) it may be due to obstruction of the portal vein; (3) it may be due to some pathological condition of the peritoneum.

(1.) *Ascites as part of a general dropsy.*—We are yet a long way off having an exact appreciation of the causes of general dropsy; but we may state that the two most important factors as far as we can understand them now, are, some alterations in the blood pressure within the capillaries, or some changes in the physical condition of the blood, which cause or allow the serum more easily to transude through the vessel-wall. Now, I can give you no better example of general dropsy due to an altered state of pressure within the vessels than in the case of chronic cardiac failure, whether primary or secondary. And I cannot give you a better example of general dropsy due to some altered state of the blood than the general dropsy in that form of Bright's disease which we know as chronic tubal nephritis. Cardiac and renal disease are the only two conditions producing a general dropsy which commonly becomes sufficiently marked to make the ascites, which is a part of it, a thing demanding special diagnosis. But, even so, as long as the ascites in these cases is proportionate to the dropsy in other parts of the body, there will be no very great difficulty in recognising the cause of the ascites, even for the least experienced. But you must remember that although we talk of general dropsy, or of general anasarca, it is very rare for this condition to be uniformly distributed all through the body. You are constantly reminded that in the general dropsy resulting from Bright's disease the eyelids and scrotum are likely to be affected before there is any dropsy in other parts, and that dropsy having got the lead in these positions frequently remains very much more prominent there than elsewhere. You know that in heart disease the dropsy may be confined to the lower extremities until the last few weeks of life, only becoming truly general when the patient is *in extremis*. The explanation of the want of uniformity in these two conditions is generally regarded as simple. We are told that in the dropsy of Bright's disease the localization to the eyelids and scrotum is due to laxity of the tissues there, we are told that the dropsy in heart disease specially affects the legs while the patient is walking about, and the back while he is lying

in bed, because of the effect of gravity, gravity determining the fluid to the most dependent parts. But there are cases in which the disproportionate distribution of the general dropsy is not so easily explained.

When the disproportion takes place so that the peritoneal effusion is in great excess, then a difficulty may arise as to the recognition of the cause of the ascites. And it will not be enough for you to assume that because a patient with disproportionate ascites has also symptoms of heart disease or kidney disease, the heart disease or the kidney disease is the primary cause of his general dropsy, and the cause, therefore of his ascites. You must remember that a patient with very great ascites not due to heart disease at all, may have symptoms of heart disease; the pressure of the ascitic fluid upon his diaphragm may interfere with the action of his heart so as to cause an irregularity of the pulse. The heart may be so displaced that a bruit may be produced. These cardiac symptoms and physical signs are the effect of the ascites and do not point to its cause. On the other hand, a patient with a large amount of ascites may have his renal veins so pressed upon that there may result albuminuria and a deficient excretion of urine. Before you decide that the primary disease is in the heart or kidney you must find more reliable signs than irregularity of pulse or albuminuria.

But I would also have you remember that in a case of disproportionate ascites which is undoubtedly part of a general dropsy, it is possible that there may be some added condition which will explain the disproportionate amount of the ascites. If, for example, in a case of Bright's disease the ascites is out of proportion to the dropsy elsewhere, you will often find in the post-mortem room that your patient has been the subject of perihepatitis, and may rightly conclude that some of the ascites is due to portal obstruction. And similarly in cases of chronic cardiac disease, you may find changes in the liver causing special pressure upon the portal vein. Such local explanations are not, however, by any means always found. It is often pointed out to you that patients with chronic cardiac failure, say from mitral disease, shew evidences of this failure very much more in one part of the circulation than they do in another. For example, the patient may have a very large liver and very little dropsy in his legs; or he may have a great deal of albuminuria and no signs of pulmonary engorgement; and I would have you consider whether it is not possible, in any such case, that the dropsy being specially marked in one part may be an explanation of its not being so well marked in another; in fact, that excess in one direction may act as a sort of safety valve in other directions. Just as, for example, a series of villages may all be in danger from a river in flood, and the majority of them may be saved by one village being entirely overwhelmed. It appears that sometimes in cases of general dropsy with ascites, the ascites becomes disproportionate because the effusion having begun in that direction it becomes the point of least resistance and lessens the pressure in other parts of the body. Those are some of the points which you will have to bear in mind in determining whether or not to place a case of ascites under group 1.

I now come to group 2, *obstruction to the portal vein*. And here I must ask you to bear with me whilst I state three propositions which I think will help you to decide whether ascites is due to portal obstruction. Firstly, if ascites is due to portal obstruction there may be evidence of other results of portal obstruction. Secondly, the condition which causes pressure on the portal vein may give other evidence of its existence. I will give you examples later on to make this clear to you. Thirdly, if ascites is due to portal obstruction, the lesion producing the obstruction may be associated with other lesions having the same cause. Perhaps those propositions want a little amplifying. Let us take them *seriatim*. First, the existence of other signs of portal obstruction. If ascites is due to portal obstruction it is likely that that obstruction will produce effects elsewhere, *i.e.* other parts which are drained by the portal vein are likely to be involved; the spleen is likely to be enlarged; the patient is likely to be suffering from hæmorrhoids; you are likely to obtain a history of hæmatemesis, or of the patient having passed blood in the motions. If the ascites is

due to some condition of the liver causing pressure upon the portal vein, this condition of liver may possibly—I will not say certainly—give other signs of its existence. That is to say, if the pressure upon that vein is due to dissemination throughout the liver of a large amount of fibrous tissue, that tissue will probably cause palpable enlargement or hardness of the liver. It is possible, also, that this connective tissue in its contraction may produce obstruction upon the bile ducts, causing jaundice. The third proposition I submitted to you was, that the lesion producing the portal obstruction may be associated with other lesions having the same cause. If, for example, portal obstruction is due to alcoholic cirrhosis of the liver—and it commonly is—you are likely to find evidences of the action of alcohol, not only in the liver, but in other parts of the body; on the patient's complexion, upon his mind, and upon his nervous system generally. But when you have placed your case into this particular category you have still to determine which of the various forms of portal obstruction is at work. A very large majority of your cases of portal obstruction will be due to cirrhosis of the liver, and a very large majority of these again will be due to alcohol. That provides for us a tempting prospect: in all cases of portal obstruction let us diagnose alcoholic cirrhosis of the liver, and in the great majority of cases we shall be right. This is a method of diagnosis which I must not commend to you. If we are ever going to diagnose accurately the cases forming the small minority it must be by knowing of their existence. I cannot do more than enumerate them now; but to help you to remember them, I would say that portal obstruction must clearly be due either (1) to some obstruction of the radicles of the vein in the liver, or (2) to some obstruction to its main trunk in the portal fissure. The conditions which obstruct the portal vein by compressing all its radicles throughout the liver are three. Firstly, there is perihepatitis, when the liver has a thick capsule outside it, which squeezes it up, like hands compressing a sponge; and this, by its gradual contraction, obstructs the smaller branches of the portal vein. And there is the diffuse growth of fibrous tissue which you find in cirrhosis of the liver, and which most commonly leads to obstruction. Thirdly, you may have a diffuse growth of malignant disease all through the liver, which, by its gradual compression, obstructs the distributing radicles of the portal vein. The obstruction in this case may be as complete as that which results from obstruction of the main trunk of the portal vein. With regard to the latter, I would remind you of the possibilities of malignant disease of the liver, or of the glands in the portal fissure, or of some other viscus near at hand compressing and occluding the vein. Adhesive pylephlebitis may by thrombosis give rise to complete obstruction in the main trunk, or in its radicles in the substance of the liver.

We now come to Group 3, *ascites due to peritoneal lesions*, or to some definite disease of the peritoneum itself. Here at once we come to a method of diagnosis of quite a different character. There are three things likely to happen if there is a definite disease of the peritoneum, which are not at all likely to happen if there is merely an effusion poured into what is an otherwise healthy peritoneum. If there is a definite disease of the peritoneum in association with ascites, there are likely to be adhesions between various parts of the peritoneum; there are likely to be deposits in the glands or in the omenta, primary disease giving rise to secondary deposits, and there is likely to ensue a contraction or shrinking of the omenta and the mesenteries. These three factors, which are never present in cases of ascites in which the fluid is poured out into a perfectly normal peritoneum, are of the greatest assistance in enabling you to diagnose the existence of some disease of the peritoneum. If the ascites is associated with adhesions between the different parts of the peritoneum you may at once find that the fluid is loculated, and this will lead to an absence of the free interchange of dulness and resonance as the posture of the patient is varied. You know that one of the characteristic signs of ascites is demonstrated by the way in which the resonant upper part of the abdomen becomes dull when the patient turns on to his side. If there are adhesions, this very striking

phenomenon of alternating dulness and resonance will not be present. Another point is that if there are adhesions there may not be the perfect mobility of the intestines which causes the normal abdomen to feel absolutely uniform wherever you press it. Indeed, a normal abdomen feels more like a bag of fluid than a cavity containing coils of intestines; this is because the intestines are so beautifully soft and smooth that they glide away from your pressure. But where there are adhesions there is a lumpy feeling, due to masses of unequal resistance in different parts of the abdomen. More defined masses are likely to be produced by deposits of growth or caseous material in the lymphatic glands or elsewhere. Lastly, there is the shrinking of the mesentery, which takes place in association with peritoneal diseases causing ascites. The conclusive evidence of this you will rarely come across, but when you do I hope the deduction to be drawn from it will at once occur to you. In all other forms of ascites you will find an area of resonance somewhere in the front of the abdomen, where the intestines float to the surface. But when there is contraction of the mesentery the intestines are bound down into a mass in front of the spine, and consequently the ascitic fluid gets in contact with the whole anterior abdominal wall and produces a uniform dull note.

These special signs are never present in common uncomplicated ascites with a healthy peritoneal surface. When they are present you may exclude groups 1 and 2, and come definitely to the conclusion that your case is in group 3. While their presence is of great importance, their absence, as in the case of all negative signs, is naturally of much less value. The finding of these things will necessarily put the case into group 3, but the absence of them can only suggest to you that if in group 3 the disease is in an early stage.

Now, having placed your case into this third group you must proceed to differentiate between the possible conditions comprised within the group. The three chief diseases of the peritoneum that produce ascites are (1) tubercle in the peritoneum, (2) cancer in the peritoneum, and (3) simple chronic peritonitis. Tubercle and cancer you will generally be able to recognise, because the patient is likely to have definite symptoms of tubercle and cancer, either as a result of the disease upon the body generally, or as a local effect in some other part of the body. The pyrexia of tubercle, or the cachexia of cancer, may be associated with the presence of tubercle in other parts of the body or of some primary visceral cancer. Ascites associated with firm masses within the abdomen in a young subject is likely to be tuberculous; in an elderly subject, is likely to be cancerous.

When you can exclude either of those specific causes, you must place your case under the heading of simple chronic peritonitis, which is a condition that is not very clearly defined. It seems likely that a large number of cases of so-called simple peritonitis are really instances of tubercle of the peritoneum. You know that it is not uncommon to find patients dying of chronic forms of lung disease in which no specific evidence of tubercle can be found at the autopsy, and yet as to which we are confident that in their early stages they were tuberculous in origin. So probably many of these cases of so-called chronic simple peritonitis are really cases of long-standing tubercle in which the evidences of the initial disease have passed away. Another thing I would like you to think of with regard to cases in which you are disposed to diagnose this so-called simple chronic peritonitis is, that ascites may be the cause of chronic thickening of the peritoneum as well as the result of it. The finding of a thickened opaque peritoneum in association with ascites does not always warrant the conclusion that the effusion is the result of the chronic inflammation. I am confident that in cases of cirrhosis of the liver which are many times tapped, the thickening of the peritoneum found at the post-mortem, and which is by some thought to be the essential cause of the ascites, is really merely a secondary result of the long-present ascites.

I have set before you three groups, and some indications as to the special features of each group. I have also given you lists by no means complete of the various causes in each group. But I cannot say that I have exhausted the subject of the diagnosis of ascites; it is a very

difficult subject. The reference I have made to the two obscure cases I am in contact with at the present moment should be sufficient to show you how difficult the subject sometimes is. But in many cases it is easy, and in very few is it impossible, and I am sure you are much more likely to make an accurate diagnosis if you will usually approach a case whether it gives prospect of being difficult or not in the way I have just suggested.

I promised to say something about the treatment of ascites; but, just as I have been only able to touch the fringe of the subject of diagnosis, so I shall only be able to speak to you about the treatment of ascites as a symptom in itself. Clearly I cannot go now into the treatment of all these conditions which produce ascites. But you will have noticed that many of these conditions which produce ascites are in themselves incurable; and when it falls to your lot to have to do with such a case, you will often have to treat what is for the moment the most urgent condition, namely, the pressure-effects of the ascites. Whenever the amount of the ascitic fluid is sufficient to displace and interfere with the action of the heart you must carefully consider active treatment for the relief of pressure. The treatment resolves itself into attempts to promote reabsorption, and direct measures to remove the fluid. A method of promoting reabsorption much in favour is the inunction of the abdominal wall with mercurial ointment. You will see this method employed, however, chiefly in one particular variety, namely, the tuberculous. It is doubtful whether it has much effect in other forms of ascites.

In cases in which you are certain of, or suspect a tuberculous origin, you will do wisely to rub into the abdominal wall and keep closely in contact with it, by means of a flannel bandage, a certain amount of dilute mercurial ointment, taking care, however, that you do not set up troublesome inflammation of the umbilicus, which sometimes results from repeated mercurial inunction.

Next, we come to the various drugs likely to promote absorption. They are chiefly diuretics and purgatives. At the same time, iodide of potassium holds a valued place in promoting the absorption of this fluid. You should, however, remember that in any of these methods of promoting the absorption of fluid it is important not to allow the patient during the treatment to drink an unlimited quantity of fluid. If you are employing diuretics and purgatives, and at the same time allowing the patient unlimited liquid, it is much more likely that the increased excretion of fluid will be derived from the fluid drunk by the patient than from that accumulated in the abdomen. It is therefore wise in these circumstances, to strictly limit the amount of fluid, so far as this may be done without causing serious inconvenience to the patient. The most popular diuretic at this hospital for the treatment of ascitic fluid is copaiba; one ounce of the Guy's Pharmacopœial mixture given three times a day produces most beneficial results. It is generally said that this drug should only be employed in cases where the kidneys are healthy. If the ascites is part of a general dropsy, and the general dropsy is due to Bright's disease, it is not likely that you will get such successful results by giving active diuretics.

Now, you will frequently find that your attempts to promote reabsorption will not be speedily successful. In all cases they must take a considerable time, and you may often be called upon to treat the pressure effects of ascites under conditions admitting of no delay. In such cases, and in more chronic cases after a prolonged trial by means of drugs without success, it becomes necessary to remove the fluid by mechanical means. The simplest mechanical means is by Southey's tube. I remember the time when abdomens were tapped with instruments of very much larger calibre than those now employed. In fact, it was not uncommon for the ex-dresser to go into the medical wards and tap three abdomens on one evening, and he would stay by each patient's bedside during the time the fluid was being evacuated. That will give you an idea of the rate at which the abdomen used to be emptied some few years ago. You will not be surprised that rather serious symptoms sometimes followed the tapping; in quite a number of cases the operation gave rise to syncope. The modern method of using an instrument of small calibre, and leaving

it in the patient's abdomen for from twelve to twenty-four hours, allowing the fluid to drip out in a very small quantity at a time, is much more satisfactory. It is practically free from danger, because if you are sure of your asepsis the proceeding can do the patient no harm.

Now, I want to consider with you whether this drawing off of the fluid may be regarded as curative, or only palliative. Personally, I must confess, I have seen but little evidence that it is curative. I am familiar with cases which have been tapped, and in which the fluid has never re-accumulated, but I have not felt confident that it ceased to re-accumulate because the abdomen had been tapped; I have regarded such cases as probably cases in which, if the abdomen had been left alone, the fluid would have been gradually absorbed. But it is a reasonable suggestion that the withdrawal of a certain quantity of fluid, by lessening the tension, may enable the circulation of the peritoneum to deal with the remaining quantity. Many physicians teach that you should tap ascites early, as soon, in fact, as there is any discomfort. Although that may be right with regard to a certain small proportion of recent cases, in which a curative effect is hoped for, in the more chronic cases which have been repeatedly tapped I think we must recognise it is not so, and that in those cases you will only hasten your patient's end by tapping him too frequently. Think of a case which is being tapped time after time, say every month, or every two months, and consider what is likely to be the difference in the amount of fluid which the patient loses into his abdominal cavity the day before and the day after the tapping. I cannot estimate it in quantity, but you can imagine that the day before the tapping, when the patient's abdomen is greatly distended, there must be difficulty on the part of the circulation in adding even a few drops to the enormous accumulation already there. On the other hand, the day after the patient has been tapped, and when the abdomen is flaccid, and there is only such pressure as you are able to employ by means of a towel carefully arranged about the patient's abdomen, you can see there is no material pressure to prevent re-accumulation of the fluid, and the patient will probably in twenty-four hours succeeding his tapping lose a considerable quantity of fluid. I say "lose" advisedly, because fluid which is poured out from the circulation into the abdominal cavity is practically lost to the patient. So when you are considering the tapping of ascites as a palliative measure, the principle you should go upon is to encourage the patient to put up with the discomfort of the distension as long as she may or can. And notice in this respect the great difference there is between the tapping of a chronic accumulation of fluid in the abdomen and tapping an accumulation of fluid in the pleural cavity. In the latter case the reason that determines the time of tapping is our consideration on behalf of the lung. If the lung is compressed for any considerable length of time, it will not re-expand when the fluid is withdrawn. As far as the abdomen is concerned there is no structure which we know of that gets permanent harm by the continued presence of the serous effusion. Therefore we have only to tap under conditions when the patient is in considerable discomfort from upward pressure into the thorax. I think I have already said that in acute cases possibly the tapping may have a curative as well as a palliative effect and the time chosen for the operation may be determined on different principles. Paracentesis is the usual and almost universal method of removing ascitic fluid, but in a certain number of cases it is proposed that laparotomy should be performed. You possibly remember the tale of Sir Spencer Wells, who in operating for what he thought was an ovarian cyst, found in the peritoneal cavity free ascites, with numerous tubercles on the serous membrane, and immediately closed the abdomen, regarding the case as hopeless and expecting the patient to rapidly die: the patient, however, speedily recovered. Ever since then laparotomy in tuberculous peritonitis has held a prominent position. We must not forget that in cases of tubercle of the peritoneum the patients often lose their ascites without laparotomy. During the last six months I have twice considered with my surgical colleagues the advisability of operating upon patients suffering from tuber-

culosis of the peritoneum, and on both occasions the ascites gradually disappeared before a definite decision to operate was arrived at. Some surgeons record very successful results, and laparotomy deserves careful consideration in all tuberculous cases which do not show signs of improvement by simpler measures.

An operation has recently been introduced whereby after laparotomy, irritative adhesions are set up between the surface of the liver and the anterior abdominal wall, in the hope that in these adhesions new vessels will be formed and establish a free collateral circulation. This procedure is stated to be beneficial in cases of ascites due to portal obstruction. The results in the few instances in which I have seen this method of treatment employed have not encouraged me to recommend its adoption.

Presentation Day at the London University.

WEDNESDAY, June 24th, was a notable day in the annals of the London University. The Senate had decided to mark the occasion by conferring, for the first time in the history of the University, honorary degrees upon distinguished persons. Their choice fell upon the Prince and Princess of Wales, Lord Kelvin, and Lord Lister. Having embarked upon this venture it was evident that such a concourse of people would wish to be present that the "*Grand Hall*" in the University buildings would be quite insufficient for the purpose. So our impecunious, houseless, and *parvenu* university, was compelled to hire the Albert Hall for the occasion and confer its honorary degrees in a concert room. Apart from this grievance, which is keenly felt by all London University men, the Albert Hall was a distinct success for the occasion. Its size and space, and style of architecture are all eminently suited for a great gathering, and as everybody present was invited to wear academic costume, the effect was magnificent in the extreme. Everybody of any standing in the scientific or medical world of London was present, and representatives of the Colleges of Surgeons and Physicians and the local municipalities all added brilliancy to the scene.

The presentees, among whom was the present writer, were collected in various "crush rooms," a very apt title by the way, and sorted out, gowned, implored to sit down, made to stand up, roll called, and marshalled till a long procession was formed; we then marched round the outside passages of the Albert Hall, as the Jews round Jericho, and finally emerged into the middle of a blaze of colour from the grand entrance opposite the organ. The procession went straight up the centre of the Hall and found a resting place on the orchestra in front of the Royal Choral Society, who were there to make as much music as they could out of "God save the King" and "God Bless the Prince of Wales."

Once seated, the time was occupied in waving to fond parents and friends till the Lord Chancellor's procession arrived. This, the most magnificent of all, was composed of the Steward, the Secretary to the Senate, and the three Registrars, who register everybody and everything from University Extensions to mere Externals; following these came the Senate, in all colours of the rainbow and of all degrees of beauty. Wild horses would not drag from me the name of him reputed to be the fairest, but they do say that he looks better with his wig than without it. After the Principal (Sir Arthur Rücker), the Member for the University (Sir Michael Foster), the Chairman of Convocation (Sir Edward Busk), Lord Lister and Lord Kelvin. Then came the new Vice-Chancellor, Dr. Pye-Smith, just in front of their Royal Highnesses, the Prince and Princess of Wales, who both, and especially the Princess, looked splendid in their scarlet robes. After the Prince and Princess came the Mace bearer, or the Esquire Bedell, and the Chancellor, Lord Rosebery, in his gorgeous heavily embroidered gold laced robes, and the only one in the whole assembly wearing his hat.

Being seated, the business began. The Principal read out the annual report of progress to the multitude, but as his countenance was turned away from us, we didn't hear much. No doubt, however, he spoke the truth.

The report over, the Prince of Wales and Dr. Pye-Smith rose and bowed to the Chancellor. The Prince of Wales stood facing the Chancellor while Dr. Pye-Smith addressed him in a stage aside.

In a very neat speech, Dr. Pye-Smith eulogized the Prince's virtues, and presented him to the Chancellor for the honorary degree of Doctor of Laws. Then the Chancellor, in his most impassive manner and impressive voice, by virtue of his office as Chancellor, and in the name of the Senate, admitted him to the degree.

The Prince having been allowed to look at his diploma to see that it was true, that document was at once taken away again, and he resumed his seat.

Dr. Pye-Smith again rose and bowed to the Chancellor and then to the Princess, who stood up and faced the Chancellor, as her husband had done. Dr. Pye-Smith then presented Her Royal Highness for the honorary degree of Doctor of Music. In that speech of presentation, only half a dozen lines long, in scholarly English, graceful and courtly, Dr. Pye-Smith rose to the occasion in a manner which few men in London could equal. It was as perfect an example of what a speech should be as any we have heard for many a long day.

The Princess smiled, and bit her lip to keep from more than smiling, at the eulogy, and was also admitted to her degree by that graven image of a Chancellor, who unbent but for a moment, to kiss her hand.

Lord Lister and Lord Kelvin, the one so tall, and the other so small and old, were then admitted to the honorary degree of D.Sc., the former being presented by Mr. Butlin, and the latter by Professor Tilden.

Immediately after this the crowd of presentees began to leave the orchestra in single file on either side, walked round the arena, met at the end and advanced up the centre in twos. Arrived opposite the Chancellor they were marshalled into groups of eight, drawn up in front of the daïs, and thus admitted to their degrees in batches, the process reminding one somewhat of a confirmation or an adult baptism.

All went well during this process till a Miss Eva Richardis Cyriax arrived to take a B.Sc. Immediately, from a corner of the gallery, arose a most unearthly noise and screaming, punctuated by an intermittent rattle. This was Bedford College expressing its joy at the success of a colleague, and Bedford College so shrieked at intervals throughout the evening We think they were ill-advised to do so, for two reasons; firstly, that it is childish, and secondly, that women cannot cheer, but only scream as if hurt, and look anything but nice in the doing of it. It is to be hoped that next year they may find a less painful method of congratulating fellow students.

In about thirty minutes 413 presentees were sworn in and despatched to their original seats in the most methodical manner, and then Lord Rosebery rose to make his address. In this he was disappointing, for he said very little though he said it well, and although very rightly he made a point that the University would be wise to be parsimonious in giving honorary degrees, he gave no word of congratulation to those upon whom he had just conferred their ordinary degrees, and who had been working for their distinction through long years of steady labour.

This speech done, the Chancellor's procession formed up and departed whence it came, and the show was over.

No account of the evening would be complete without a word of congratulation to Professor M. J. M. Hill, of University College, who was responsible for the admirable stage management of the evening.

The Guy's men who took their degrees on June 24th at the Albert Hall were as follows:—

M.B.—Hugh Barber, Marcus Woolf Cohen, George Evans, David Forsyth, Norris Norman Allen Houghton, Greer Edmund Malcomson, Sidney James Ormond, Morgan James Rees, Carrick Hey Robertson, George Struan Robertson, Frank Leslie Thomas.

B.S.—Alfred Gelsthorpe Osborn.

M.B. and B.S.—Percy William Leopold Camps, Michael Abdy Collins.

M.S.—Herbert Lightfoot Eason, Russell Henry Jocelyn Swan.

D.Sc.—John Wade, Frederick Gowland Hopkins.

M.D.—Thomas Henry Bourne Dobson, Dudley George Greenfield, George Norman Meachen.

The following Guy's men took special honours:—Arthur Boniface O'Brien (Exhibition and Medal in Anatomy, and Exhibition and Medal in Organic Chemistry at the Intermediate M.B.), Richard William Allen (Exhibition and Medal in Materia Medica at the Intermediate M.B.), and Robert Pugh Rowlands (Scholarship and Medal in Medicine at the M.B.).

The New Knights

SIR EDWIN COOPER PERRY was educated at Eton where he was a King's scholar and head of the school. He took the Newcastle Scholarship and went to King's College, Cambridge, in 1876. In 1880 he became a Senior Classic, and was elected a Fellow of King's College. After this he went to Leipzig for a year to study music, among other things, and during that period revised the King's College Psalter. Subsequently he commenced studying for medicine, and after having passed his earlier examinations he entered the London Hospital in 1884. Here, Dr. Perry was House-surgeon to Frederick Treves, and immediately afterwards he was H.P. to Dr. Stephen Mackenzie, who by a singular coincidence was knighted on the same day as his old House-physician. While still an H.P. at the London Hospital, he was appointed to the post of Assistant-physician to Guy's, at that time as now one of the most exclusive of all the London hospitals. Dr. Perry was at once made Sub-Dean, to Dr. Frederick Taylor, Physician to the Skin Department and Demonstrator of Morbid Anatomy.

Dr. Perry was the prime mover in the foundation of the College, which was built while he was Dean, and was opened in 1890. Mr. Gladstone on that occasion paid him a memorable compliment when he remarked that the man who formed the College finances deserved to be a Chancellor of the Exchequer.

In December, 1892, Dr. Perry was appointed Superintendent of the hospital, and has held that post uninterruptedly since. To those who have watched the progress of the hospital since that time, the changes here, all in the direction of progress, and marked by rare constructive ability, have been a triumphant vindication of the wisdom of that choice.

The Superintendent has been entirely responsible for bringing up to the level of modern requirements an institution in which everything had been let slide for nearly forty years, and also for the much greater personal interest and satisfaction that the Treasurer and the Governors have latterly taken in their work at the hospital. His motto here would most aptly be that of Sir Christopher Wren, "Si monumentum requiris circumspice." The College, the renovation of the wards, the Nursing Home, Petersham, and the new school buildings, all testify to his incessant care. In 1897, Dr. Perry was despatched to Cairo to reorganise the Hospital and Medical School, and by those who know, this is regarded as the most convincing proof of his organising ability. In a short five weeks he perfected

a scheme for both institutions, which has worked perfectly ever since, and has not needed the slightest alteration.

In 1900 Dr. Perry was elected to the Senate of the London University as representing the medical faculty, and has had a large share in the reorganisation of the University.

After the war in South Africa Dr. Perry was nominated to the Army Medical Advisory Board, and for his most successful labours in reorganising and popularising that neglected service, it is generally understood that he has been given his recent distinction. On that board he at once made his mark, and is generally recognised now as the power behind the throne in that department. Now as recently as May 15th he has been appointed Chairman of the Army Hospitals Committee, on which the only other civilian is Sir Frederick Treves, and whose scope is to initiate a scheme for renovation of the military hospitals of the empire.

In this brief sketch we have of necessity omitted Dr. Perry's numerous posts in metropolitan hospital and municipal movements and any mention of his services here as physician and pathologist. Such is a short record of, we hope, a small portion of a life which has been most aptly described by one of our busiest and most successful physicians, who said that Dr. Perry was always "a standing disgrace to him for wasting his time."

Sir Alfred Downing Fripp entered Guy's in 1884. He was secretary and subsequently captain of the Rugby football team, and first started the Yorkshire tour to play such clubs as Bradford and Wakefield Trinity. These tours were the first forerunners of our present Welsh and foreign tours.

Mr. A. D. Fripp, as he was then, was also for four years in the cricket eleven, during which time they always held the Cricket Cup.

R.O. in 1889, he was subsequently H.P., being the last of the old residents and the first of the new régime in the College in 1890, and continued for an extra three months, thus being one of the few H.P.'s who have done nine months' work in the wards.

In 1890 Mr. Fripp attended the Duke of Clarence in Scotland, and subsequently went away with him for three months. From that time till the death of the Duke of Clarence he was personal medical attendant to His Royal Highness.

Mr. Fripp was demonstrator in the dissecting-room from 1890 to 1897, and during that time, especially when junior demonstrator, he was with Dr. Shaw entirely responsible for the formation of the present Clubs' Union, the levelling and improving of the ground at Honor Oak Park, and the arrangement of the Clubs' Union finances; he was also for four years secretary to the Students' Club.

In 1897 Mr. Fripp was appointed Assistant Surgeon to the Hospital and immediately afterwards was appointed Surgeon-in-Ordinary to His Majesty the King, then Prince of Wales. His tenure of that high and responsible post has always been an unmixed blessing for Guy's, for Mr. Fripp has always used his great opportunities to the utmost to benefit this hospital. In that same year the Prince of Wales had an injury to his knee and Mr. Fripp was in personal attendance upon him at Cowes for three months. In February, 1900, Mr. Fripp went to South Africa with the Imperial Yeomanry Hospital, for whose inception, organisation, and successful management he was entirely responsible, the Imperial Yeomanry Hospital at Deelfontein being unanimously acknowledged the most completely organised and thoroughly equipped of any hospital at the Cape.

In South Africa Mr. Fripp was accompanied by his wife, who was universally admired and liked, and Mrs. Fripp was one of the few women out in South Africa who by her unfailing charm and tact never made an enemy or lost a friend. For her services she was decorated on her return with the Royal Red Cross.

At the close of the war, during the chorus of destructive and wild criticism of the Army Medical Corps, Mr. Fripp kept a very wise silence, and occupied himself with advocating reforms in that service, and suggesting alternative schemes. He was appointed to Mr. Brodrick's Committee in 1901 for the re-organising of the Army Medical Service, and assisted in drawing up the Report of that Committee. The Report resulted in the formation of the present Advisory Board with its perpetuation of the civilian element as represented by Sir Frederick Treves, Professor Ball, Professor Galloway, Sir E. C. Perry, and Sir Alfred Fripp. On that board Mr. Fripp has always worked hand in hand with Dr. Perry, each knowing the other thoroughly and uniting their several abilities to the common good.

Immediately upon the accession of the King Mr. Fripp was made Surgeon in Ordinary to His Majesty, and still holds that post. Still a young man, Sir A. D. Fripp deserves the most heartfelt thanks of Guy's Hospital for having throughout a life that reads like a fairy tale always taken or made his opportunities, and turned them solely for the benefit of his hospital with no thought of advertisement or personal advantage.

Prizes.

TREASURER'S GOLD MEDALS, JUNE, 1903.

Clinical Medicine.—Mr. N. Ivens Spriggs, Medal; Mr. N. F. Bell Walker, Prox. Access.

Clinical Surgery.—Mr. G. C. F. Robinson, Medal.

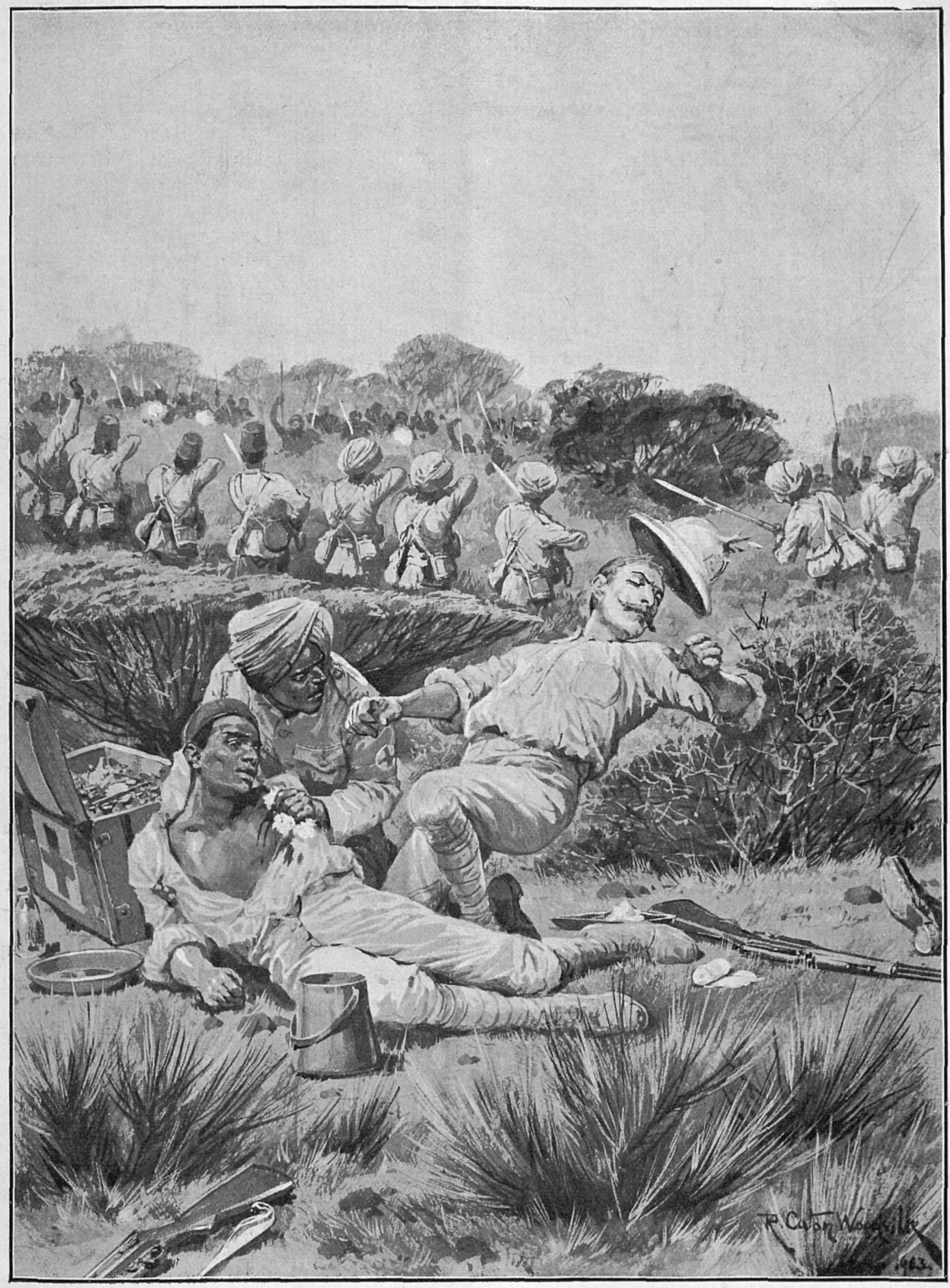
DENTAL PRIZES, JUNE, 1903.

First Year's Students.—Mr. A. Alan Forty, Prize, £10; Mr. H. Poyton, Certificate.

Second Year's Students.—Mr. Richard Roberts, Prize, £15; Mr. A. E. D. Prideaux, Certificate.

Practical Dentistry Prize.—Mr. A. E. D. Prideaux, Prize, £10; Mr. Richard Roberts, Certificate.

On Active Medical Service.



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The Death of Capt. SIME, I.M.S., April, 1903, in Somaliland.

Passim.

In our last issue we had the pleasure of announcing that Princess Christian had become President of the Guy's Hospital Ladies' Association. In the annual report of the Association, a copy of which we have just received, we note that Her Royal Highness will receive the support, as Vice-Presidents, of the Duchess of Portland, the Duchess of Wellington, the Countess of Selkirk, the Countess of Waldegrave, the Countess of Iddesleigh, the Countess of Bective, Lady Edward Spencer Churchill and Vicountess Valentia.

The Association has during the eight years of its existence done a great deal of good work for the patients by providing them with clothes and arranging for ladies to visit them while in the hospital. For the last two years it has supported three of the maternity beds by an annual donation of £150, and we understand it has the laudable ambition of ultimately supporting all the eight beds in Victoria ward. The kindly interest of the Royal President and her distinguished Vice-Presidents cannot fail to be of great assistance to the Executive Committee, who have already shown much capacity in organization.

The work of the Association is carried out by a main body and a number of local branches, the management of each branch being entrusted to an honorary secretary. The branches at present number fourteen, and the Committee in their annual report, appeal to ladies interested in the hospital to undertake the formation of additional branches. Many of the existing local secretaries are the relatives of old Guy's men who have become interested in the work of the hospital through their husbands or brothers. By giving publicity to the Committee's appeal we hope to be able to secure the formation of additional branches. The following are those already instituted, with their respective honorary secretaries:—Balham, Mrs. Octavius Bevan; Bayford and Bickendon, Mrs. Charles Barclay; Berkshire, Mrs. Parry Price; Brighton, Miss Dunn; Cambridge, Mrs. Mollison; Clapham, Mrs. Thorpe; Cobham, Mrs. Arthur B. Hudson; Denmark Hill, Mrs. Bramley Taylor; Dover, Mrs. Arthur Osborn; Dulwich, Miss Willson; Hampstead, Mrs. Layton; East Norfolk, Miss Daniel; West Norfolk, Miss Beck; Woodford, Mrs. C. E. Edwards.

For our part we cannot help thinking that much assistance might be given to the Association if we, the present students, would endeavour to interest our mothers and sisters in the work. As clerks and dressers we cannot fail to notice whilst in the wards, the poverty of many of the patients, and to appreciate the advantage it is to such to have decent clothes provided for them in which to go to a convalescent home or to seek fresh employment.

The Annual General Meeting which takes place in the summer affords an occasion for displaying the clothes made by the various branches during the year. The officers and executive committee also have the opportunity of meeting the members and honorary secretaries of local branches and discussing with them the means of furthering the work of the Association. A copy of the last annual report will be sent to anyone applying for it, and offers of help will be gratefully received by the hon. secretary of the Association, Mrs. Lauriston Shaw, 64, Harley Street, W.

At a meeting of the General Court of Governors of Guy's Hospital on June 26th it was unanimously resolved, on the proposal of the Prince of Wales, President, seconded by Mr. Cosmo O. Bonsor, the Treasurer, that Mr. H. Beerbohm Tree be elected a Governor of the Institution. At the same Court Mr. C. H. Goschen was also elected a Governor, and a vote of congratulation was ordered to be entered on the minutes to Dr. E. C. Perry and Mr. A. D. Fripp, of the Hospital Staff, on the honours conferred on them by the King.

Michael Biddulph, J.P., D.L., now Lord Biddulph of Ledbury, has been a Governor of Guy's since 1864. He is a partner in the well-known banking firm of Cocks, Biddulph & Co.,

was member of the House of Commons from 1865 to 1900, first as a Liberal and later as a Liberal Unionist.

GENERAL SIR RICHARD HARRISON, K.C.B., C.M.G., R.E., has been promoted to the dignity of G.C.B. His honours are the result of a long and distinguished military career, starting with the Indian Mutiny, the siege of Lucknow. He served in China, the Cape, being at the battle of Ulindi. He went to Egypt and fought at Tel-el-Kebir, and he has recently vacated the post of Inspector-General of Fortifications.

WE must congratulate Dr. T. W. S. Paterson, of St Thomas's, on the result of his action against the P. and O. Steam Navigation Company. "In July of last year Mr. Paterson went to Japan as surgeon to the ss. 'Socotra.' Before starting, he was asked to sign the ship's articles, as required by the Board of Trade. Pasted on to the articles were two bye-laws of the Company, one of which was to the effect that the Company might transfer him at any port to another ship, if it suited their convenience. Dr. Paterson, wishing simply to go to Japan and back, refused to sign these articles at first, but consented on being given a verbal promise that this bye-law would not be acted on. However, on arriving at Shanghai, on the homeward voyage, he was ordered to transfer himself to a ship plying between Bombay and Shanghai. This he refused to do. He was prosecuted at H.B.M.'s Police Court, Shanghai, for refusal to obey the lawful command of the captain. He defended himself, pleading that the command was not a lawful one, as the Merchant Shipping Act of 1894 says, 'A captain shall not leave or cause to be left behind a seaman in a foreign port.' The magistrate decided that the Company's bye-law did not over-ride the articles prescribed by the Merchant Shipping Act, and dismissed the charge. The Company appealed against this decision, but the acting Chief Justice of the Supreme Court of China and Korea dismissed the appeal with costs. They then applied for and obtained permission to appeal to H.M.'s Privy Council in London. Dr. Paterson thereupon instructed his solicitor in London to proceed with an action in the High Court, London, claiming damages against the Company for malicious prosecution. The defendant Company, while denying liability, paid £555 into Court, as sufficient to satisfy the plaintiff's claim. This sum Dr. Paterson accepted, and so the action terminated without a public hearing in court, the Company paying also the plaintiff's taxed costs of the action. The result of this case should be an example to other members of our profession to stand up for themselves. Dr. Paterson was placed in a very embarrassing situation at the first action in Shanghai, as he was unable to obtain legal assistance, owing to want of ready money, but he defended himself with skill in a position in which many of us would have given way."—*St. Thomas's Hospital Gazette.*

WE hear that Dr. E. W. Ainley Walker, our Gordon lecturer in Experimental Pathology, has been elected to an official Fellowship at University College, Oxford. Although Dr. Walker has only been at Guy's for a comparatively short period, his appointment here having commenced in January, 1902, we hope that he has enjoyed his period of work here and will regard himself for the future, as we shall certainly look upon him, as a Guy's man. Dr. Walker has been carrying on valuable research work in the Gordon laboratory, as may be seen from the various papers already published. We are sorry he is so soon to leave us, but at the same time offer him our most hearty congratulations upon his appointment and our best wishes for his success and welfare in the future. By-the-bye, we notice that the Gordon lectureship will be vacant from October 1st next and that application should be sent to the Secretary of the Board of Electors on or before July 16th next.

BY the courtesy of the Editor of the "Illustrated London News" we are enabled to reproduce a sketch made by their correspondent in Somaliland and completed by the well-known military artist, R. Caton Woodville. It represents the death of Captain F. W. Sime, I.M.S.,

whose death was recorded in these columns, and though his close friends may be inclined to cavil at the likeness, we think many will be glad of a picture representing a risk of our calling that the public rarely appreciates, but which the South African Memorial in the Colonnade bears a striking witness.

We heartily congratulate Miss Hodges on her appointment at Bradford Infirmary as Lady Superintendent. For many years she was well known to Guy's men as Sister Mary and eventually became Assistant Matron. It was a great loss to Guy's when she accepted the post of Matron of the Carlisle and Cumberland Infirmary, but our loss is most distinctly their gain. Her many friends at Guy's wish her success in perhaps the most trying position in a hospital.

Guy's Hospital has good reason to be proud of the honours conferred upon Sir E. C. Perry and Sir Alfred Fripp. For their own sakes the distinctions have been welcomed with the greatest outburst of enthusiasm, for it is universally felt that they have been most thoroughly deserved and earned by much quiet and good work, and the fact that two members of the same hospital Staff should be honoured on the same occasion, cannot fail to redound to the credit and increase the prestige of our famous medical Staff.

To glance at the particulars of the lives of the Superintendent and Sir Alfred Fripp, which we publish in another column, is enough to make one gasp at the amount of work which has been crowded into a few short years by both of them, and to almost despair at ever attempting to approach two careers of such unbroken success. So alike in some respects, and so different in others, Sir E. C. Perry and Sir Alfred Fripp have each in their way, by supplementing each other's talents, done a great work for the hospital and the medical profession at large. The marvellous memory for detail and gift of forgetting that detail when considering a broad scheme of reform exhibited by the Superintendent, and the unapproachable charm of manner and social influence wielded by Sir Alfred Fripp, have, during the past two or three years, been bearing wonderful fruit.

We cannot publicly state as much as we know concerning the intimate details of the private history of Guy's during recent times, but when in due time these things can be told, it will be more fully realised what a great service has been rendered to the hospital, both socially and internally, by the two eminent members of our Staff whom the King has delighted to honour.

Change of Address.

Dr. George Black has moved from Hurstpierpoint to 15, King Edward Street, Oxford.

Mr. A. Drewitt, L.D.S., from Harrogate to Eversleigh, Brighton Road, Purley, Surrey.

Mr. P. J. Reid, L.D.S., from Aldershot to Lyndholme, Chertsey Road, Woking.

Dr. H. W. Roberts, from Lewisham High Road to 3, Breakspear's Road, St. John's, S.E.

Dr. G. Hook Rodman, from Heathcote to Sheen Gate House, Sheen Lane, East Sheen, S.W.

Major J. V. Salvage, R.A.M.C., has been transferred from Kandia, Crete, to Salisbury Plain.

Dr. W. E. Sturges-Jones, from Payta, Peru, South America, to 1, Sternhold Avenue, Streatham Hill, S.W.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Reviews.

The price of books submitted for review should in every case be stated.

A Manual of Surgical Treatment. By Watson-Cheyne and Burghard. Part II., Section II. (Messrs. Longmans Green & Co.) 1903. Price 21s. net.

This, the second of Part VI., completes a well-known work of established value, and is the largest of the series.

It maintains the standard of its predecessors, and gives all the ordinary surgical methods, and indications for operation clearly, sensibly, and on the whole, definitely.

The authors lay great stress on the fact that they were stimulated to record their experiences by the lack of after-treatment details in other works, but here as elsewhere, the details are still vague. Probably it is better so, for detailed instructions are apt to mislead the unwary.

The vexed question of Freyer's operation is not much discussed, and this part is perhaps rather weak; we note that castration appears decidedly disliked. Perhaps the greatest omission of a really excellent work is that it does not give the results of operation sufficiently definitely, and that the return of old patients that most surgeons know so well, is passed over with scant mention, and that the risk of the various operative procedure are somewhat slurred over, and yet the probable result of any given operation is perhaps the most important point to consider.

Guy's Hospital Children's Home Sale of Work and Garden Fete.

FAVOURED by brilliant weather, the Sale of Work and Fete which took place in the grounds of Guy's Hospital Nurses' League, Dunoon Road, Forest Hill, on Saturday last, was a pronounced success both financially and socially, and the excellence of the general arrangements provided ample opportunity for the numerous visitors which thronged the grounds from 3 to 10.30 p.m., to enjoy themselves, which indeed they did.

The stalls, erected under the direction of Mr. Pelling, the Hospital Clerk of the Works, and beautifully decorated by their respective holders, and the marquees and tents by Messrs. B. Edgington, Limited, left nothing to be desired, and it was amid most picturesque surroundings that Mrs. Cosmo Bonsor arrived promptly at three o'clock to open the proceedings. The ceremony took place on the Tennis Court in front of the stalls, and in calling upon Mrs. Bonsor, the Treasurer of the Home, Mrs. C. H. Wells made the following statement:—

"Lady Bective, Mrs. Bonsor, Ladies and Gentlemen,—On behalf of the Council of the Guy's Hospital Children's Home, I heartily welcome all who come to help us to-day, and I sincerely thank them whether they be sellers or buyers. And especially do I offer gratitude to those friends who by generous gifts or hard work have contributed to make this occasion successful and profitable. Many of us present are acquainted with the aims and work of the Home. To anyone good enough to desire information I shall be delighted to send a copy of our last Report. I should like, however, to assure everyone that the Home is doing a most valuable work and that the general condition of the little ones entrusted to our care would be a credit to any similar institution in the land. And, as Treasurer, I am thankful to state that the Home is most economically conducted. We have had to be very, very economical because we are very poor, but, in spite of that, no child entrusted to our charge has ever lacked anything; and I submit it is to the greater credit of the Home that such excellent results should have been obtained at so small a cost. But economy can be cut too fine; our present income is really insufficient; repairs to the structure are inevitable; and our aim to-day is to raise £600 with which to repair the home, to discharge the mortgage liability, and to supply for the next few years the existing deficiency in income. I have the greatest pleasure in asking Mrs. Bonsor to declare our proceedings open."

Mrs. Bonsor thereupon declared the Sale and Fete open, at the same time expressing the pleasure which it gave her to do so, knowing, as she did, what a good work the Home was doing.

The Countess of Bective in a sympathetic speech moved a vote of thanks to Mrs. Bonsor and all those helping on the occasion, and business was proceeded with and a brisk trade done till closing time.

The following is a list of the Stalls and Stallholders:—

General Stalls.—Mrs. H. Cosmo Bonsor, Lady Evelyn Goschen, Mrs. Arbuthnot Lane, the Matron, Sisters, and Nurses of the hospital. The Countess of Bective, Lady Henry Bentick, Mrs. Eason, Mrs. Higson, Mrs. Wells, and Forest Hill ladies. The Hon. Mrs. Talbot, Miss Gardiner, Mrs. Fagge, Mrs. H. M. Stewart, and ladies of Guy's Staff. Mrs. Kirby, Miss Grossmith, Miss Layman, Mrs. Parry, and Shortland ladies. Flower Stall.—Mrs. M. Trevelyan Martin and Mrs. Herbert Raphael. Refreshment Stall.—Mrs. R. A. Hankey and Lady Cooper Perry. Irish Dairy Stall.—Miss Cary Jepson and the Misses Corneille. Parcels Stall.—Lord Arthur Hill and Mr. Curry.

All the ladies named were present and worked strenuously, and the assortment of articles offered for sale and sold were remarkable for their value and attractiveness.

As to the Refreshment department, always an important consideration at these functions, the effectiveness of its working may be judged from the fact that upwards of three hundred teas at one shilling per head were served with alacrity, not to speak of a continuous supply of strawberries and cream and other light refreshments, while in the evening a substantial supper was served and everything eaten up. Mrs. Hankey and Lady Cooper Perry are to be heartily congratulated on the success of their efforts in this direction.

Of the side shows and variety entertainments under the respective directions of Mrs. John Fawcett and Mr. H. M. Woodward, more could be written than we have space for, but, from the professional variety entertainments down to the cocoanut shies, not one of these lacked an appreciative and profitable audience, and while any good cause connected with Guy's Hospital can always depend upon the good offices of Guy's residents and junior men, it was very gratifying to find such eminent professional entertainers as Miss Constance Collier, Miss Nina Hill, Miss Manley, Miss Viola Tree, Miss Coralie Blythe, Miss Beatrice Wilson, Mr. H. W. Brodie, Mr. Lawrence Grossmith, and others, coming so far on a Saturday afternoon to give such first-class turns on behalf of a modest little charity.

In addition to the stalls, the following attractions were provided:—Variety Entertainments, Fine Art Gallery, Shooting Gallery, Aunt Sally, Cocoanut Shies. Weighing, Measuring and Strength-testing Machines. Band of "M" Division, Metropolitan Police. Illuminations.

As regards the variety entertainments, there can be only one opinion. They were, in the rich metaphor of the Orient, "a success right away from the word 'jump.'" Those who were fortunate enough to be present in that canvas cauldron, the Entertainment Tent, will class the performances amongst the most brilliant ever held in connection with Guy's Hospital.

To satisfy our readers' morbid love of detail, we will make an attempt to describe each item *seriatim*. To begin with, there was Miss Constance Collier, who was looking, if possible, more magnificent than ever, and

whose thrilling rendering of Adelaide Ann Proctor's "Requital," called forth a clamorous demand for an encore, which Miss Collier graciously responded to with an admirable rendering of an anonymous poem, "The Prisoner's Prayer." Miss Coralie Blythe and Mr. Lawrence Grossmith delighted their audience with the tea-shop scene from the "Three Little Maids." Miss Blythe was altogether charming, and her song, "You Men," was irresistible, whilst Mr. Grossmith as the fatuous Lord Cheyne kept his audience in fits of laughter, his song, "Algy's awfully fond of Algebra" being particularly amusing. Miss Nina Hill's singing of "Spring is here," accompanied at the piano by Lady Arthur Hill, won a well deserved encore in the first concert, whilst in the second, these two ladies uniting their forces, in a brilliantly executed duet, again delighted the audience. Miss Manly's recitation setting forth the difficulties of ice-skating for a novice was very amusing, whilst Miss Beatrice Wilson's singing won an unhesitating encore. Mr. Brodie's singing of "Nothing new" and "Bobs has had some useful tips from me" was intensely comic. Miss Cordelia Grossmith accompanied. Mr. Charles Brown, of the Gaiety Theatre, and Mr. Woodward caused much merriment by their clever rendering of "The East End and the West," from the Toreador. The motoring finale was funny in the extreme, and these gentlemen wish to express their thanks to the menials at the wings who so ably "made noises." Mr. Ticehurst's performances at the piano were very highly appreciated, and Mr. Ellis with his song, "Modern Love," was at his drollest.

The Evening Concert also was exceptionally good' Mr. Ticehurst opened with Rachmaninoff's "Prelude," in his usual excellent style. Mr. Caple-Beadle's rendering of the "Song of Hybrias the Cretan" was most stirring, whilst Mr. Stanley Hazell, as composer, accompanist and singer of "Mr. Peter Potter," literally convulsed his audience, who were treated to an Irish brogue song as an encore. Mr. Ray Edridge recited Gilbert's "Troubador," and followed it up with an "Immortal Fable," by Barry Pain, as an encore. Mr. Leonard Ransford's whistling of "When the Swallow's homewards fly" and "Let us forget," by Maude Verie White. was much appreciated. As an encore Mr. Ransford whistled, "Sing me to sleep," by Edwin Greene. Mr. J. E. Collins thrilled his audience with a melodrama "Gertrude" or "The Worst Man in London," and his encore, "Wheezes," concerning fish-kettles and cuckoo clocks were received with roars of laughter. Mr. Roy Ellis sang the "Simple Country Curate" with telling effect, and as an encore he perpetuated a little ditty which gave us his very decided views on some articles of ladies' millinery. The diligent band of the M division of Metropolitan Police were exceedingly anxious to punctuate his clerical efforts with the "Sacbut, psaltery, dulcimer, and all kinds of musick," but were tactfully dissuaded from so doing by three actor fellows.

During this concert Mr. Larkin kindly accompanied at the piano.

The side shows attracted continuous crowds, and materially aided in producing pleasure and profit. Mr. Kirwan presided over the Fine Art Gallery, and Mr. French and Mr. R. O. Williams over the Weighing, Measuring and Strength Testing Machines, while Messrs. J. M. Brydone, C. J. Pinching, C. A. Ticehurst, A. C. H. Gray, F. C. Wetherell, F. D. S. Jackson, O. V. Payne, R. Ellis, R. O. Williams, L. Pallant, E. W. Sheaf and J. E. Collins, and others, whose names we regret to be uncertain of, did yeoman service in running the Shooting Gallery, Cocoa-nut Shies, Aunt Sally, and in working the auditorium for the Variety Entertainments.

The excellent band of the "M" Division of Police most kindly gave their services free during both afternoon and evening, rejoicing in the opportunity of helping their old friend Guy's Hospital, and the illuminations by Mr. Joseph Wells gave a charming finish to an occasion of which we have heard nothing but congratulation and praise.

It only remains to add, and we have authority for stating, that the financial result will come within measurable distance of the desired six hundred pounds.

A Dental Meeting.

My attention was diverted by the sound of music of a wild and saracenic description resounding from the exterior of the building. The melody appeared to be that portion of the "Battle of Prague" which represents the "cries of the wounded" accompanied by an unlimited amount of exertion on the part of the operator on the brass drum. Hastily rushing to the window, I beheld a procession, numbering some three or four hundred, all in their Sunday clothes, every man with a cigar in his mouth, slowly and solemnly moving past the hotel. They bore a banner at their head, on which was depicted an enormous corkscrew, or some instrument of that description, with the motto, "A long pull, a strong pull, and a pull altogether." Judge of my astonishment and delight in recognising in the bearer of this banner my old friend the philanthropic tusk-maker of widespread renown. As the procession reached the front of the hotel each man threw away his cigar, and having replaced it by a large quid of tobacco, defiled on the esplanade beneath the piazza in a tolerably straight line, and then gazed intently at the windows, opened his mouth from one external auditory meatus to the other, and *showed his teeth*. Never have I seen so glittering a display! Filled with curiosity, I was about to ask an explanation when my friend Doolittle, from Androscoggin, who had rushed to the window at the same time with myself, saved me from the trouble by demanding, with an incoherent and exceedingly nasal pronunciation, "Why, what on airth is this 'ere?" "This" replied the courteous Hiram, whose suavity of manner is only equalled by the beauty of his person, "this, sir, is the American Dental Association, composed of members from all parts of both Continents and the British West India Islands."

"JEREWSELEM!" said Doolittle, "THREE HUNDRED TOOTH CARPENTERS." It *was* indeed a thrilling spectacle. To think of the amount of agony that body of men had produced, and were capable of yet producing!! To think of the blood they have shed, and of their daring and impetuous *charges* after the gory action was over! The immortal charge of the six hundred at Balaclava was not a circumstance to the charges made daily by this three hundred. As Hiram had truly said, these were dentists from all parts of the civilized world and elsewhere. There was the elegant city practitioner, with shiny hat and straw-coloured gloves, side by side with the gentleman from the country, who hauls a man all over the floor for two hours for a quarter of a dollar, and gives him the worth of his money. I observed that 47 of them wore white hats, and 268 used tobacco in some form. There can be no question that this substance is a preservative to the teeth. I observed in the rear rank the ingenious gentleman who invented the sudden, though painful, method of extracting a tooth by climbing a tree and connecting by a catgut string the offending member with a stout limb and then jumping down: a highly successful mode of operation, but not calculated to become popular with the community. He wore buckskin moccasins, and did not appear to be enjoying a successful practice!

But while I gazed with deep interest upon the assembly the band struck up "Tom Tug," and away they went. Three times they encircled the hotel, then, "with their wings aslant," like the fierce cormorant, swooped down upon the bar, registered their names, and took a grand united Federal drink, each man paying for himself. Here toasts and sentiments were the order of the day.

"The American Dental Association, like watermen, we pull one way and look another," "A three-dollar cavity, very filling at the price, "The woodcock—emblem of dentistry—he picks up his living from the holes and passes in a precious long bill."

These, with other sentiments of a similar meritorious character, were given, and received with great applause. Having all drunk from the flowing bowl, the Association again formed in line in front of the piazzas, which were now crowded with a curious and admiring throng, and sang with surprising harmony the following beautiful, plaintive and appropriate chant:—

"Oh, Jonathan Gibbs, he broke his tewth,
A eatin' puddin', a eatin' puddin';
Jonathan Gibbs be broke his tewth,
A eatin' puddin', a eatin' puddin'.

"Great lumps of suet they stuck intew it,
Intew it, intew it, intew it, intew it,
Great lumps of suet they stuck intew it,
As big as my two thumbs."

This chant finished, and the applause subsiding, an air of gravity came over the Association, and the President, Dr. Tuskmaker, stepping forward, announced that a few pleasing and wonderful performances would now be gone through with the object of exhibiting the dexterity acquired by the members of the Society. Then, turning to the line, he gave the command, "Draw!" In an instant every one of the Association was armed with a brilliant turn-screw, "Fix!" shouted Dr. Tuskmaker, and each member opened his mouth and attached the fearful instrument to a back tooth. "Haul!" screamed the doctor. "Hold, for heaven's sake," shouted I, but it was too late; three hundred double-fanged back teeth, dripping with blood, were held exultant in the air. The Association looked cool and collected; there might have been pain, but, like the Spartan boy, they repressed it; the ladies, with a wild cry of horror, fled from the piazza. "Replace!" shouted Dr. Tuskmaker, and in an instant every tooth returned to the mouth whence it came. I understood it at once—it was ball practice with blank cartridge—they were all false teeth. Several other interesting exercises were gone through. A cabman passing by on his carriage was placed under the influence of chloroform, all his teeth extracted without pain, and an entire new and elegant set put in their place, all in forty-two seconds! His appearance was wonderfully improved; he had been known for years as "snaggled-toothed Bill," but a new and more complimentary title will have to be devised for him. At five o'clock the procession was re-formed, the band played "Pull, Brothers, Pull," and the Association moved off.

I have never seen three hundred dentists together before, and don't believe anybody else ever did, but I consider it a pleasing and improving spectacle, and would suggest that the next time they meet they make an excursion which shall combine business with pleasure, and all go down together and remove the snags from the mouth of the Missouri.—*Manchester Medical Students' Gazette.*

Cricket Club Annual Dinner.

ON Saturday, June 20th, Dr. Brailey kindly gave his customary dinner to the members of the Cricket Club, past and present. The dinner was held in the reading-room in the college, and about forty people sat down to the excellent repast provided by Mr. Wade. Dr. Brailey presided, and among the guests were Mr. Bellingham Smith, Dr. Eason (Warden of the College), the President and others of the Residents, and a few members of the past team. Unfortunately, the state of the ground at Honor Oak caused the Past v. Present match to be put off, and this was the cause of so few of the "Past" team being present. The customary toasts were given and responded to, and many agreeable and amusing speeches were made. Mr. "Jumbo" Wetherell especially distinguished himself when proposing the health of our kind host Dr. Brailey, to whom he accorded all the virtues. Songs, comic and otherwise, were well rendered by Messrs. Ellis, Felton, Wyatt, Plummer and Bookless, ably accompanied by Mr. Larkin. The evening terminated with "Auld Lang Syne," and thus ended one of the most enjoyable and successful dinners ever given by our kind host and president, Dr. Brailey.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Guy's Hospital Children's Home.

Dear Mr. Editor,—May I through your columns thank all those Guy's men who helped with the entertainments and side-shows at the Garden Fête on Saturday last? The energetic way in which they worked resulted in a substantial addition to the proceeds of the Fête.—Yours very truly,

MAY F. FAWCETT.

26, St. Thomas's Street, S.E.

The Use of the Library.

Dear Sir,—A proposal has been made to the Committee of the Students' Club that the reading-room in the College should, during the winter session, be used as a smoking-room, between the hours of 12 noon and 2 p.m. The reasons advanced for making this suggestion are: that the smoking-room is uncomfortably full about that time, and that the Wills Library will then be open, and Members wishing to read might do so there.

The reading-room is to be used for smoking and talking only. No food is to be served or partaken of there, and before and after these hours the room is to be used, as before, for reading, silence being maintained. The Committee would like to know the opinion of the Members with regard to this alteration before deciding.—I remain, yours truly,

ARTHUR N. ORMOND,
Hon. Sec.

June 26th, 1903.

Pass List.

University of Oxford, June, 1903.

EXAMINATION FOR THE DEGREE OF M.D.

G. G. Davidson.

EXAMINATION FOR THE DEGREE OF M.Ch.

F. E. Fremantle.

SECOND EXAMINATION FOR THE DEGREES OF M.B. and B.Ch.

J. M. Bickerton, W. E. Robinson, P. N. Blake-Odgers, A. R. Wilson.

University of Cambridge, June, 1903.

DEGREES OF M.B. and B.C.

W. H. Brailey, M. C. Hayward, E. H. Kitchin, F. B. Manser, F. Richmond, H. Wacher, J. A. Wood.

DEGREE OF M.B.

N. F. Ticehurst.

DEGREE OF B.C.

H. Ackroyd. H. Davies-Colley.

THIRD EXAMINATION FOR THE MEDICAL AND SURGICAL DEGREES.

Part I.—A. R. Brailey, S. Child, J. S. Cooper.

Part II.—H. Ackroyd, A. R. Brailey, W. H. Brailey, H. A. Cutler, F. B. Manser, F. Richmond, R. D. Smedley.

SECOND EXAMINATION.

R. Davies-Colley, C. F. Fothergill, C. W. Greene, G. W. de P. Nicholson.

Appointments.

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants.—Messrs. F. W. Fawssett, H. C. C. Mann, E. W. Strange, Kenneth Black, L. S. H. Glanville, A. R. Brailey.

Dressers in the Throat Department.—Messrs. A. M. Webber, R. G. Anderson, M. G. Louisson, F. H. Wallace, H. M. M. Woodward, O. V. Payne.

Clerk in the Throat Department.—Mr. M. Bramley Taylor.

Obstetric Dressers.—Messrs. M. J. Mottram, H. H. Jenkins, W. F. Box (July 1st).

Assistant Surgeons' Dressers.—Messrs. F. M. Longson, A. B. Cocker, R. P. Lewis, E. White (Mr. Lane); R. O. Williams, H. V. Mitchell, W. Welchman, M. Maher (Mr. Dunn); A. H. Clough, J. E. Scales, C. M. Wenyon, R. A. Chisolm (Mr. Fripp); L. Doudney, H. P. Costobadie, T. Turner, L. G. Davies (Mr. Steward).

Medical Ward Clerks.—Messrs. L. J. Patterson-Clavier, J. A. C. Greene, H. M. Langdale, C. W. R. Preston, R. W. Allen, A. D. Crofts, V. A. P. Costobadie, W. C. M. Dickey, A. B. O'Brien, M. de L. Robinson, R. D. Barron, H. C. Cameron, F. D. Crew, R. E. French, G. H. K. Macalister, A. H. Miller, M. MacPherson, G. Hamilton, W. P. Purdom, E. H. Adams, R. J. Bentley, H. S. Knight, M. Leckie, E. F. Milton, F. A. Sharpe, H. A. Watney, F. T. H. Wood, E. Bellingham Smith, B. B. Metcalfe, T. Norman, H. F. Wight, R. S. Harper, E. E. Rendle, G. W. Nicholson, A. Morris, T. C. Pocock.

Assistant Physicians' Clerks.—Messrs. W. C. M. Dickey, M. de L. Robinson (Dr. Shaw); F. D. Crew, A. H. Miller (Dr. Bryant); H. M. Langdale, L. J. Patterson-Clavier (Dr. Fawcett); H. C. Cameron, G. H. K. Macalister (Dr. Beddard).

Surgical Ward Clerks.—Messrs. R. M. Wingent, A. G. Jones, J. B. Ball, L. H. Burner, W. H. S. Burney, T. R. Harvey, J. H. Mayston, G. H. Morris, C. F. Fothergill, H. G. Gibson, W. H. Robinson, A. S. Morton Palmer, T. H. Barton, G. N. Bartlett, I. R. Cook.

Clerk in the Skin Department.—Mr. E. Lloyd.

Post-mortem Clerks.—Messrs. E. Lloyd (July–August); E. L. Ward (August–September).

Dental Surgeons' Dressers.—Messrs. E. H. B. Milsom (August–September); H. Watts (September–October).

Aural Surgeon's Dressers.—Messrs. M. J. Mottram, W. T. P. Meade-King.

DENTAL APPOINTMENTS.

The following appointments have been made by the Treasurer upon the recommendation of the Dental Council:—

Dental House Surgeons.—Messrs. H. P. Aubrey, F. W. Parfitt.

Assistant Dental House Surgeons.—Messrs. A. E. D. Prideaux, C. W. Randall.

Demonstrators in the Conservation Room.—Messrs. N. Mc L. Nibbs, E. L. Pilbeam, H. Poyton.

Dressers in the Gas Room.—Messrs. S. H. Barlow, J. W. Mawer, R. J. Messent, R. C. Mungal, G. G. Timpson, H. E. Warren-Williams.

Casualty Dressers.—Messrs. P. E. Luce, H. J. Snowden, F. S. Vine.

NAVAL AND MILITARY.

Staff-Surgeon HORACE B. MARRIOTT, R.N., is appointed to the *Tribune*.

Captain BAMAN DAS BASU, I.M.S., is promoted to be Major.

Lieutenant M. H. THORNELY, I.M.S., is promoted to be Captain.

Lieutenant A. W. SHEEN, Volunteer Infantry Brigade Bearer Company, Wales, is promoted to be Captain.

NURSING.

Miss ELIZABETH HODGES has been appointed Lady Superintendent of the Bradford Royal Infirmary. She was trained at Guy's Hospital, where she was night sister, sister of Mary ward, and assistant matron. She has since been matron of Cumberland Infirmary, Carlisle.

Miss E. GERTRUDE HOBBS has been appointed Night Superintendent of the West Ham New Infirmary. She was trained for three years at Guy's Hospital, has since been staff nurse at the Royal South Hants and Southampton Hospital, charge nurse at the Northern Fever Hospital, Winchmore Hill, sister at the London Female Hospital, Harrow Road, and sister at Lewisham Infirmary.

Papers by Guy's Men.

A Clinical Lecture on Bilharzia. By J. H. Bryant, M.D., F.R.C.P.—*Clinical Journal*, June 24th.

A Brief Note on a Bacillus in a Case of Ulcerative Colitis. By Theodore Fisher, M.D., M.R.C.P. Lond. (Illustrated).—*The Lancet*, June 27th.

Sport.

Cricket.

GUY'S v. ST. THOMAS'S.

INTER-HOSPITAL SENIOR CUP.—FIRST ROUND.

Being so fortunate as to win the toss for choice of ground, this match was played at Honor Oak on Saturday, June 27th. Guy's won the toss, and on a splendid wicket, Barber and Morres put up 50 runs before being separated. A fairly good start thus being made, everybody proceeded to make runs, and a total of 289 was run up. Wyatt, Willan and Foster played good innings, and it was pleasing to note that the former has regained some of his form. The last three wickets put on 90 runs, Foster hitting in excellent style. Thomas's, after making a great start, putting up 90 for first wicket, were dismissed three minutes before 7 p.m. for 201. Wyatt bowled excellently, and Barber's donkey-drops were most effective; he performed the hat trick, and took in all four wickets for 17 runs. Scores:—

GUY'S.

H. Barber, lbw, b Cheadle	30
F. Morres, b Footner	21
H. M. Langdale, b Hoare	34
A. B. O'Brien, c Dixon, b Footner	6
H. D. Wyatt, c Hoare, b Footner	46
R. Willan, b Starkey-Smith	42
E. Morgan, b Starkey-Smith	10
E. A. Collins, b Starkey-Smith	7
L. G. Davies, c & b Hewett	26
A. L. Foster, b Hoare	41
M. G. Louisson, not out	12
Extras	14
Total	289

THOMAS'S.

G. R. Footner, b Foster	48
F. M. Nield, c & b Barber	75
C. M. Bernays, c O'Brien, b Wyatt	5
F. S. Hewett, b Wyatt	0
S. R. Gibbs, b Wyatt	0
B. A. Cheadle, b O'Brien	15
C. M. Page, c Willan, b Barber	26
T. G. Starkey-Smith, c Morgan, b Barber	0
G. J. Langley, c Louisson, b Barber	0
A. N. Dixon, not out	5
N. S. Hoare, b Wyatt	3
Extras	24
Total	201

GUY'S v. BART.'S.

SEMI-FINAL CUP-TIE.

Played at Hale End on Monday, June 29th. Guy's won the toss again, and Barber and Morres put up 166 runs

without loss before lunch. On resuming, Morres left at 182, and with Langdale in runs came at a good pace. Barber next left, having played a splendid innings for 134, his cutting being excellent, and the total then stood 282. After Langdale left for a hard-hit innings of 52, wickets fell somewhat rapidly in trying to force the game, but Collins hit hard for 24, and we then declared at 344 for 8 wickets, leaving Bart.'s a little over three hours to bat. Our opponents played the goose game for all they were worth, but four minutes before time we managed to out them for 127 runs. O'Brien bowled well, taking 4 wickets for 6 runs.

GUY'S.

H. Barber, c Griffin, b Eckstein	134
F. Morres, c Hill, b Page	85
H. M. Langdale, b Eckstein	52
A. B. O'Brien, not out	18
H. D. Wyatt, c Parkinson, b. Griffin	1
R. Willan, c Griffin, b Page	3
E. Morgan, b Eckstein	7
L. G. Davies, b Page	9
E. A. Collins, b Page	24
Extras	11
Total (8 wickets)	344

A. L. Foster and M. G. Louisson did not bat.

BART.'S.

K. S. Single, b Morgan	16
L. V. Thurston, run out	22
P. Parkinson, b Wyatt	22
W. B. Griffin, lbw b Wyatt	2
W. S. Nealor, c Wyatt, b Davies	13
E. A. Dash, c Wyatt, b Foster	17
H. B. Hill, b O'Brien	5
J. Eckstein, lbw b O'Brien	6
G. F. Page, b O'Brien	9
J. Gaskell, not out	0
A. L. Symes, b O'Brien	0
Extras	15
Total	127

GUY'S v. HORNSEY.

Played at Hornsey on Tuesday, June 23rd. In consequence of the Sports next day, Guy's took down a weak side, being very deficient in bowlers, one of whom had the misfortune to strain his knee after the second over. The wicket was very sticky. Scores :—

GUY'S.

F. Morres, c Manning, b Barker	0
R. Willan, b Dent	3
H. M. Langdale, b Banker	10
F. G. Gibson, b Dent	2
E. A. Collins, b Dent	11
M. Macpherson, b Banker	15
L. G. Davies, c Wallett, b Dent	45
M. R. Smith, b Dent	10
C. M. L. Cowper, c King, b Swinsted	0
G. M. Bartlett, not out	0
T. P. Harvey, c King, b Dent	0
Extras	4
Total	100

HORNSEY.

H. B. Corry, b Langdale	3
W. E. Manning, run out	4
J. H. Nicholls, b Davies	3
L. Orton, b Langdale	2
F. H. Swinsted, c M. R. Smith, b Davies	33
F. B. Dent, b Davies	45
S. L. King, c Willan, b Langdale	54
S. M. Banker, b Davies	0
G. Hart, b Davies	0
J. H. Kemmeist, not out	2
J. A. Wallet, b Morres	0
Extras	20
Total	169

Annual Sports.

"Weather permitting" is evidently no condition—we wish to thank, not to tempt, Providence for Sports day at Honor Oak Park, as we were again favoured with a sunny and warm day for this annual event, which came off on Wednesday, June 24th. To estimate the number of visitors were no easy task; but amongst those present we noticed several members of the Staff, together with some of the Sisters and Nursing Staff, while there was a large gathering of Guy's men who, together with their friends, must have numbered some six hundred.

Of the events the donkey race was again one of the most popular items on the card, affording immense amusement to the spectators. There was much variety in the methods of the donkeys, one long-haired beast in particular causing especial fun in his attempts to get rid of his rider. The relay race, which we believe was introduced for the first time in the history of Guy's sports, developed into somewhat of a match between the two football clubs, and in spite of Morgan's great effort in the last lap, fell to the credit of the Association club.

Those responsible for the handicapping are to be congratulated on the excellent way in which they carried out such a difficult task—all the sprint races being in doubt right up to the tape. It will be seen from the list of events that all the winners are men still in the "dissecting room." The absence from the contests, with few, very few, exceptions of the senior men, was much remarked upon by those who are enthusiastic for the success of these sports. Even if their engagements did not permit the necessary training, they might at least have supported their hospital sports by entering for some of the events.

Thanks are due to Messrs. Fawcett, Bryant, Monro and Steward, who performed their arduous duties, as usual, to everyone's satisfaction.

Mrs. Bellingham Smith kindly consented to give away the prizes, and did so amid enthusiastic applause.

The band of the 5th (West) Middlesex R.V., ably conducted by Mr. M. Marks, gave an excellent programme throughout the afternoon.

LIST OF EVENTS.

100 Yards.—1. J. L. Rankine, 5 yards; 2. E. Morgan, scratch; won by inches. Time 10⅘ secs.

Putting the Shot.—1. J. L. Rankine, 35ft 8in.

Half-Mile.—1. H. W. Eccles, 20 yards; 2. W. H. Watson, 15 yards.

120 Yards Hurdles.—1. J. R. Hodson, scratch; 2. S. A. Piper, 5 yards. Time 18 secs. Won easily.

Throwing the Hammer.—1. J. L. Rankine.

One Mile.—1. E. L. Pilbeam, scratch; 2. T. E. A. Carr, scratch. Time 4–49⅘.

220 Yards.—1. E. Morgan, scratch; 2. T. B. Layton, 8 yards.

Veterans' Race (750 Yards).

High Jump.—1. T. B. Layton, 5ft 3½in.

440 Yards.—1. A. W. Berry, 5 yards; 2. W. H. S. Burnay, 8 yards. Time 54⅘ secs.

Long Jump.—1. E. Morgan, scratch; 2. A. M. Roome, 3in. 20ft 2in.

Donkey Race.—J. C. Bradbury.

Three Miles.—1. E. L. Pilbeam, scratch; 2. T. E. A. Carr, 15 secs.

Relay Race (one mile).—Association Football Team.

Guy's Hospital Rifle Association.

G.H.R. v. HIGH WYCOMBE R.C.

High Wycombe Ranges, 6th June, 1903.

	Guy's.
R. Felton	82
S. Hodgson	76
W. H. S. Burney	72
E. P. Minnett	72
L. L. C. Reynolds	71
D. Reynolds	70
A. V. Maybury	68
H. W. Bethel	55
Total	566
H.W.R.C.	669

We are much indebted to Dr. Reynolds, of High Wycombe, an old Guy's man, for his generosity in entertaining us on this occasion. It is a matter for regret that the Hospital could not muster a better team against such redoubtable opponents.

ARMITAGE CUP.

Third Shoot, Runnemede, 10th June, 1903.

R. E. French	90
J. S. Cooper	90
R. Felton	89
G. A. Ticehurst	84
F. B. Lowe	81
D. Reynolds	53
Total	487
St. Thomas's	489
St. Bart.'s	471

FELSTED SCHOOL.

Simultaneous Match. 200 and 500 yards.

Felsted	Total 329
G.H.R.A.	Total 342

The fight for the Armitage Cup promises to be a very close thing this year. So far the totals are:—

St. Bart.'s	1398
Guy's	1397
St. Thomas's	1391

Unfortunately, we are severely handicapped by our Athletic Association having taken no notice of the Secretary's appeal that the sports should not be held on the last Armitage Cup day, as last year. It is very annoying to the Association to be so little respected, with such satisfactory prospects. We hope some attention will be paid to the matter in future.

Marriages.

HARRISON—HAYNES.—On June 10th, at the Parish Church, Hove, William Walter, L.R.C.P., M.R.C.S., only son of Walter George Harrison, to Gertrude Haynes, daughter of the Rev. E. J. Haynes.

LEAHY—ALCOCK.—June 20th, at the Minster, Warminster, by the Rev. J. C. Alcock (brother of the bride), assisted by the Revs. S. Boulter and A. D. Clutsom (brothers-in-law of the bride), Alexander Edmund Butler, youngest son of the late John Leahy, M.R.C.S., etc., of Bombay, to Beatrice Muriel, youngest daughter of Dr. and Mrs. Alcock, of Byne House, Warminster.

ROBERTS—JONES.—On June 30th, at the Stanley Road Welsh Presbyterian Church, Bootle, by the Rev. Griffith Ellis, M.A., assisted by the Rev. W. Elias Williams, Hugh Jones Roberts, M.R.C.S., J.P., of Gwyddfor, Penygroes, Carmarthenshire, to Edith Mary, second daughter of William Jones, Esq., J.P., of Monfa, Bootle, and Llwydiarth, Anglesey.

WAY—TURNBULL.—On June 25th, at Christ Church, Westminster, by the Rev. Victor Seagrove, Montagu Way, L.R.C.P. Lond., M.R.C.S. Eng., of Kenilworth Lodge, Southsea, to Mary, youngest daughter of the late Thomas J. Turnbull, of St. Giles, Dorset, and of Mrs. Turnbull, of Streatham Hill, S.W.

Ed.—J. M. B.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, SECRETARY'S OFFICE, GUY'S HOSPITAL.

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING AND SIXPENCE.

Calendar of Coming Events.

July, 1903.

Sat. 18.—Messrs. Symonds and Steward's take-in; Drs., J. E. Prentis and W. N. May; Cl., L. S. H. Glanville.

Mon. 20.—Preliminary Scientific M.B. Lond. Exam. begins.
Exams. for Junior and Senior Prizes for General Proficiency, and for the Beaney Prize in Pathology begin.

Tues. 21.—Exam. in Dental Histology.

Thur. 23.—Messrs. Lucas and Lane's take in; Dr., G. Russell; Cl., H. C. C. Mann.
Lectures cease.

Fri. 24.—Exam. in Operative Dental Surgery.

Sat. 25.—Summer Session ends.

Tues. 28.—Final Conjoint Exam. begins.

Thur. 30.—Messrs. Golding Bird and Dunn's take-in; Dr., C. J. S. Dismorr; Cl., E. W. Strange.

Guy's Hospital Gazette,

JULY 18, 1903.

Composition Fees.

THE recent alteration in the method of payment of Composition Fees, whereby the cost of medical education is made proportionate to its duration, is so important a departure that we think it desirable to draw attention to the scheme which has been adopted this Session.

It appears more than doubtful whether old Guy's men, and others interested in the education of students, have appreciated the true inwardness of this arrangement. The basis on which it is framed is one which permits the diligent student to obtain his education for a considerably smaller sum than hitherto. All men will benefit by it, whether "Conjoint" or "University," and incidentally it will remove a long felt grievance of London University students. The claims of the latter have been brought very prominently before the School since it became a constituent college of the reconstituted University of London, and it has at last been recognised as anomalous that they should have to pay more for their medical education than those working for other qualifications.

The new arrangement places all students on the same footing. Previously the London University man paid 16 guineas for his Preliminary Scientific M.B. course, and then after entry as a "full" student, four annual instalments of 40 guineas each, a total of 176 guineas. The "Conjoint" man paid 160 guineas.

Consider now the new scheme. A student pays an entrance fee at the commencement of his period of "full" medical study, and after that an annual composition fee until he is qualified, irrespective of the qualification for which he is working.

A student who enters for his "Preliminary Science" course, pays a fee of 16 guineas for twelve months, and 8 guineas for each subsequent six months. The Preliminary Science course includes preparation for the Preliminary Scientific M.B. (Lond.), the First Exam. of the Conjoint Board, the First M.B. Durham or other corresponding examination.

When the student has completed this portion of his course, he will enter as a "full" student, and the fees paid by him for that Preliminary Science course will be deducted from the entrance fee due as a "full" student under paragraph B.

To take an example: a London University student may obtain his degree at the termination of five years from the commencement of his Preliminary Science course. In such a case, the fees paid by him would be 16 guineas for his Preliminary Science course, and if he passed the examination at the end of the twelve months, he would enter as a "full" student, paying the entrance fee of 20 guineas minus that already paid for the Preliminary Science course, and an annual composition fee of 30 guineas for four years, making in all a sum of 140 guineas, as compared with 176 guineas under the old scheme.

If such a student were to take six years then he would pay in all 170 guineas, or if five-and-a-half years then a proportion of the fifth annual instalment would be returned to him.

Similar advantages may, in the same way, be obtained by other students, such as those seeking qualification under the Conjoint Board, or those entering as Third Year Students.

A careful examination of this scheme leads to the conclusion that a step in the right direction has been taken, in that the School has realised that the best thing for its efficiency is for the student to become qualified in the shortest possible time. Not that the authorities want to get rid of the men as soon as possible. The School hopes that one of the chief results of this scheme will be that men may be induced to qualify as soon as possible. They can then spend any further time at their disposal in work in the wards, etc. The advantage accruing to them will certainly be greater as qualified than unqualified men, and will equally be of benefit to the hospital in providing a larger number of registered workers.

Thus, to promote these objects the School offers the industrious man a good chance of obtaining his education at a less cost than before, and at the same time allows a sufficiently wide margin for casualities. It appears to us a just and fair scheme, and one in the best interests of medical education and of the Hospital and School.

On the Indications for Opening the Mastoid Antrum.

CLINICAL LECTURE BY MR. C. H. FAGGE.

March 9th, 1903.

GENTLEMEN,—In discussing this question, I want you first to make a sharp distinction between two classes of cases, those in which the antrum is opened for acute inflammatory trouble in the mastoid antrum or cells and those in which the operation is carried out in the course of a chronic suppuration in which the antrum is involved. We shall find that the indications are widely different in these two classes and also that the operation undertaken in the second class is a much more extensive and difficult procedure.

There is, however, a connecting link between these two groups in those cases in which acute symptoms have set in in the course of a chronic suppuration, and these are best considered as coming in the first group, both as regards their indication and the operation to be performed.

In the acute cases we have a number of conditions which may be put together under the one comprehensive title of acute mastoiditis or endomastoiditis, that is a condition in which the antrum

with or without the mastoid cells is the seat of an acute inflammatory infection, which has usually already reached the stage of suppuration; here we have what is commonly called a "mastoid abscess," and it is well to appreciate that this does not mean only the presence of pus in the antrum, because it is generally accepted that pus is usually present in the antrum in cases of uncomplicated middle ear suppuration, but it means also retention of pus in the antrum, such retention being commonly due to blockage of the antral passage connecting it with the middle ear, so giving rise to the acute febrile symptoms and the physical signs which are produced by a localised collection of pus in bone in other parts of the body. Such conditions are always, as far as my experience goes, secondary to acute otitis media, if we exclude those rare cases which I have never seen, of acute primary tuberculous osteomyelitis of the mastoid process. Though the acute middle ear suppuration has usually, by the time an antral abscess is formed, forced its way out of the middle ear by perforation of the membrane, yet this is by no means universally true, and in fact the most difficult cases in which to arrive at a right conclusion are those in which there is comparatively slight evidence of the primary middle ear inflammation in which the membrane is not perforated, but the trouble seems to be accentuated in the antrum and a typical mastoid abscess results, which course is in my experience, for reasons suggested below, more commonly seen in children than in adults. When we come to define what we mean by acute mastoiditis, we find we can make the following subdivisions.

1. Acute primary mastoiditis, the class referred to above, where the mastoid cells or antrum are the seat of a coccal or tuberculous invasion primarily, this, which must be very rare, is probably even more rare than is supposed, because in my belief it includes those cases referred to above in which the primary middle ear symptoms are not marked enough to receive attention, and so by neglecting an early and thorough examination of the membrane and tympanum, the inflammatory process has been allowed to pass further than the middle ear, whereas, perhaps, by energetic and prompt local treatment the inflammation might have been cut short; a case which I shall mention later to you strongly supports this hypothesis.

2. Secondary mastoiditis. This is the common or typical form, best seen in adults in which the infection of the mastoid antrum is simply an extension of the middle ear.

3. Secondary mastoid periostitis is most typically seen in children, as the large subperiosteal abscess over the mastoid process pushing the ear forwards and outwards; here we have a secondary infection of the periosteum over the mastoid, the primary lesion being suppuration in the middle ear, and usually in the mastoid antrum. Infection of the periosteum over the mastoid takes place in two ways, most commonly through a fistula, which, in children is made by the pus through the masto-squamous suture. Another way is by extension of inflammatory products through the middle ear along the periosteum, covering the posterior meatal wall, and so on to the mastoid process. That we call a secondary invasion, opposing it to a primary infection of the mastoid periosteum, which I have never seen, and is said to be occasionally due to traumatism or to the other causes of inflammatory periostitis. In the secondary form the antrum is infected in its capacity as a connecting link between the middle ear and the periosteal abscess, but we have the disease in the antrum obscured by the obvious signs of inflammation of the periosteum.

4. This last class is simply a subdivision of No. 2; it is called Bezold's disease, after the Munich Professor who first described it. That is the condition in which perforation of the bony abscess wall does not take place through the masto-squamous suture, but takes place on the internal aspect of the mastoid process. You will remember that on the inferior surface of the mastoid portion of the temporal bone there are two grooves, one of which is for the digastric muscle, and the other on its mesial side for the occipital artery. In children, is occasionally associated with acute middle ear suppuration, a swelling in the neck situated underneath the sterno-mastoid at its insertion into the mastoid process: this may be opened

in the belief that it is a glandular abscess. It is very often found that it does not clear up as a glandular abscess should, and on further exploration one perhaps ascertains that there is a fistulous track on the inferior side of the temporal bone, leading up to the mastoid cells and antrum. That is called Bezold's perforation, or Bezold's disease, in which you have the pus travelling down into the air-cells at the apex of the mastoid process and then forcing its way inwards and downwards on the inner side of the mastoid process into the digastric fossa.

The *general signs of the retention of pus in the antrum* would be pain in the ear and about the ear. There is also tenderness on percussion and on deep pressure over the antrum. But be very careful that when you try to ascertain whether there is tenderness on pressure you press in the right place. I have mentioned this point before in another lecture. The position of the antrum is immediately above and behind the external auditory meatus. If you press deeply over the position of the antrum you will, in acute mastoiditis, find tenderness, which is confirmed by comparison with the other side. You will find there is pyrexia, which is well marked—such as a temperature of 102°—with loss of appetite, a furred tongue, and the other signs of fever, and you will sometimes find there is optic neuritis. Again, except in those cases where there is an intact drum—which are the most difficult ones to diagnose—you will not find, as some people expect, that the preceding otorrhœa has ceased, but you will find the otorrhœa still present. One is frequently asked in cases which look like acute mastoiditis, Is it not unusual for the otorrhœa to continue when there is an acute retention of pus in the antrum? It is not unusual, in fact it is the rule, that the otorrhœa should continue. I suppose the reason is that probably the retention of pus generally takes place from granulations blocking the passage between the middle ear and the antrum, and the diseased mucous lining of the tympanum goes on secreting its pus, which is discharged from the external meatus. And then there is the sign which we all recognise, and which I fear is, in many cases, the only sign sought for in the diagnosis of acute mastoid disease, and that is that the ear is pushed out by a red fluctuating swelling situated behind the ear. I want to make it quite clear to-day that though that sign is of value, it indicates a complication, viz., subperiosteal abscess rather than the actual primary antral abscess itself, and will be most common in children. It is often, especially in adults, not present when there is acute mastoiditis, and it may be present when there is no such thing as acute mastoiditis. A localised œdema over the antrum indicating pus deeply situated in the bone is of great value when present, but it is unusual.

Further, what do we find in acute cases when we examine the external auditory meatus? We find usually a profuse discharge; we find in other cases that the membrane is intact, but frequently inflamed and bulging, and in either case we may find that the posterior superior meatal wall is in its deepest part bulging downwards. That is very characteristic of retention of pus in the antrum, perhaps not in the most acute cases as seen in children, but in the subacute form and in adults, when it is a most valuable sign.

Where there is pain and temperature, and where, perhaps, the signs over the mastoid are not very definite, I think the value of this last indication alone makes it expedient in all cases to combine an examination of the membrane and tympanum with the external examination, quite apart from the fact that it is absolutely necessary to do so to ascertain the cause of the mastoid abscess, so that, by treating afterwards the cause as well as its effects, a satisfactory healing may take place.

You must not expect, however, to find this bulging of the deep meatal wall indication in the very earliest stages, for as a rule, it is not present until the process has gone on for three weeks, and often it is not discoverable until the inflammatory process has gone on some days more. So you must regard it as a late indication of pus retention in subacute cases; and it is quite natural for it to be best seen in those in whom the swelling behind the ear does not take place in an early stage and make the diagnosis certain, that is in adults. With regard to that swelling behind the ear,

by means of which the ear is pushed outwards, which, as I have remarked, indicates a sub-periosteal abscess; it is usually seen in children. Now, the reasons for this are two: first, that the retained pus within the middle ear has, in children, to burst through a relatively thick tympanic membrane; and secondly, that in children it has a very easy way out through the mastoid process, in what we call the masto-squamous suture, that is, the suture which binds the squamous-tympanic portion of the temporal to the petro-mastoid portion. Here I show you certain temporal bones of the newly-born child, in which you will see this as a well-marked suture over the anterior portion of the mastoid process, which at birth, is unclosed. If we compare this fœtal skull with this skull of a child two and three-quarter years of age, we find that in the latter the masto-squamous suture is closed. It closes in the second year of life, but the line of suture up to about the tenth year is quite weak, so that perforation of the mastoid process often takes place in that situation. And so it comes about that you find in children those well-marked sub-periosteal mastoid abscesses which push the ear forward, and which are so often a definite indication of acute mastoiditis.

When you think of those four different subdivisions of acute mastoiditis, the differential diagnosis between them and other inflammatory diseases around the temporal bone seems quite difficult. The first thing you have to diagnose acute mastoid disease from are boils of the external auditory meatus, which appears very easy indeed at first sight, but here we have, in German, a book by Körner with a whole page devoted to the differential diagnosis of meatal boils from acute mastoid troubles. I would ask you to appreciate that this is, in some cases, exceedingly difficult, for we have seen that sometimes one of the best signs of mastoid abscess is a red œdematous swelling behind the ear; now such œdema, not only behind but around the auricle, is characteristic of meatal boils, though it is true that here it is more generalised and not localised over the antrum and mastoid process; further tenderness on pressure is here most marked over the tragus, and with boils otorrhœa, if present, is usually slight and easily removed and the membrane seen beyond is normal. In fact the local examination with the speculum is the key note to the position, for remembering that these boils are always situated in the cartilaginous meatus they are easily seen, and even careful insertion of the speculum is so painful as to draw attention to the meatus as the probable primary disease. Another useful point is that in mastoid abscess with its antecedent otitis media, the hearing is always very much diminished, whereas when boils are present deafness is not marked until a late stage, which may never occur, when the meatal swelling entirely occludes the passage; the acute pain in furunculosis experienced when the patient eats or talks, or when the auricle is moved about by the observer is not seen in mastoid abscess.

I have pointed out that primary mastoid periostitis might occur, as I said, due to traumatism or colds, and would have to be diagnosed from secondary suppurative periostitis of the mastoid from antral infection. I know of no way of doing this except by incision. Again, we have to diagnose acute mastoid disease from cellulitis, a cellulitis which, in the majority of cases, is due to spreading periadenitis from glands immediately below the mastoid process, or may be due to parotitis. Recently I have seen three or four children who have been admitted into the surgical wards with swellings in the mastoid region, in whom twice certainly the diagnosis of acute mastoid affection was made when it was really cellulitis and periadenitis from suppurating glands. Not only in these two cases were the glands immediately below the mastoid process affected—and when those glands are affected it will be particularly difficult to make a diagnosis from Bezold's phenomenon—but also that gland which is situated immediately behind the auricle, and which is very prone to suppurate when the scalp is invaded with pediculi had begun to break down. In both the diagnosis was only made sure by incision. Again, the periglandular swelling in mumps, or in acute suppurative parotitis, is sometimes so great as to extend backwards and involve the parts over the mastoid process. I recently saw

a patient in Clinical who, in the course of dietetic treatment for a gastric ulcer, got suppurative parotitis. For a few days after the parotid had been incised the question was raised as to whether she had not got an acute infection of her mastoid. The diagnosis was perhaps made more difficult in that case because she had been, for some months previous to her parotitis, under treatment for chronic middle ear suppuration on this side; so you will appreciate the fact that there might be a difficulty in many cases of mumps, or any form of parotitis, especially suppurative parotitis, as in the case I have mentioned, in making a diagnosis from acute mastoid infection in all the above conditions. The diagnosis can practically only be made on a comparison of the external symptoms with the appearances of the tympanic membrane and of the meatus; and if the diagnosis is then uncertain the best line to adopt is the line I think surgeons usually adopt when an abscess is present and its causation is doubtful, namely, exploration, *i.e.*, exploration of the pus-containing cavity and even exploration as far as an incision into the periosteum over the mastoid process. I think by the time you have incised the periosteum over the mastoid you have got evidence that the cause is either outside or inside the temporal bone. And if by any chance you should make a mistake and come to the conclusion that the cause is outside when it is really an antral abscess, your treatment will be quite on the right lines for incision of the periosteum over the mastoid process, a very excellent preliminary treatment for pus in the mastoid antrum and cells—because, especially in children, it is not the outer layers of the bone which prevent the pus coming to the surface, it is the dense, strong fibrous periosteum. My last point will be easily appreciated as we now consider the three lines of treatment which one adopts in acute mastoid suppuration. They are: (1) paracentesis of the drum, (2) Wilde's incision, and (3) what is called Schwartze's operation. What I have spoken about as incision through the mastoid periosteum extending down to the bone is simply Wilde's incision. Until some twenty-five years ago, when practically the first mastoid operations were undertaken, the common treatment of inflammatory processes in the mastoid process was an incision behind the ear, which was first suggested by Sir William Wilde, of Dublin, and therefore called his incision, and it is a line of treatment which has up to the present day been of extreme value under certain conditions, that is, where you might not have the opportunity of performing a definite mastoid operation, or where you could not procure the help for doing so. A free incision over the mastoid process, a quarter of an inch behind the attachment of the ear, behind the sulcus which separates the skin over the ear from the skin over the mastoid, extending down through the periosteum to the bone, will in the majority of cases serve as an outlet for pus and prevent—which is the chief thing one wants to prevent in acute mastoid disease—the further progress internally of suppuration; I mean extension to the posterior or middle fossa of these infective processes.

With regard to paracentesis, in those cases—which are not common—where there is pain over the mastoid process, tenderness, temperature, and general signs of fever, in which the drum is intact, the first line of treatment certainly ought to be paracentesis. That is usually followed by the most satisfactory results. It is not only seen in children, but it is often seen in adults, as in a case I recently saw of a lady who was suffering from chronic purulent rhinitis, for which she was in the habit of using some form of nasal douche. Using this unusually vigorously one day she felt a sudden pain in the ear, which was followed, within twenty-four hours, by great tenderness over the mastoid process, for which she saw an aural surgeon. He passed the case on to me, saying he thought she had acute mastoiditis with an intact drum. The drum was reddened and slightly bulging; tenderness on percussion, and pain over the mastoid process were well-marked and entirely prevented her from sleeping. There were particular reasons why it was inadvisable to operate radically for the next twenty-four hours, and so one did paracentesis, which was easily performed under gas. Almost immediately, that is to say, within a few hours, it was found that the tenderness and very slight swelling which had taken

place over the mastoid process—rather an œdema of the mastoid coverings than any evidences of pus under the mastoid periosteum—subsided, and practically within twenty-four hours all evidences of acute retention of inflammatory products had passed away.

The third procedure which we can adopt in acute cases is what I have called Schwartze's operation. I have been especially careful to give it to you under that name because there are so many of these mastoid operations, and all sorts of wrong people get the credit for introducing them. The usual antrectomy which you see performed here in acute cases is Schwartze's operation; that is to say, a curved incision is made immediately behind the ear, which after free separation of the periosteum forwards and backwards, exposes the suprameatal triangle; through this the antrum is reached with a gouge or burr and its outer wall is then freely removed, so that the antrum is at the bottom of a funnel-shaped cavity, of which the external opening is the widest part. In these acute cases we shall commonly find either pus or septic granulations, or some other evidences of acute disease in the antrum; and in acute cases, especially in children, the operation is of the easiest, because you nearly always have that fistulous tract leading from the masto-squamous suture into the antrum as your guide. If pus or granulations are found in the mastoid cells they are treated in exactly the same manner.

The whole cavity, which has as its deepest part the antrum, and possibly the inner wall of mastoid cells, is packed with any form of antiseptic gauze, for instance, cyanide gauze wrung out in 1 in 2,000 perchloride solution; and a similar piece of gauze in placed in the external auditory meatus, and the usual dressings applied. This operation, which is so useful in acute cases, is valuable in this way, that the middle ear is left intact. You are operating for acute retention of pus in the antrum or mastoid cells; the trouble has passed beyond the middle ear into the antrum; and there is not the slightest value in removing any part of the walls of the middle ear, even though we believe it was the original cause of the disease, because it is found—and your common experience will tell you this—that in acute cases, when the antral wound granulates up from the bottom, and the cavity becomes replaced by a firm mass of fibrous tissue, no further inflammatory process takes place in the antrum or mastoid cells. Further, if the gauze strip in the auditory meatus is occasionally changed you will find that in the course of a few days, in these acute cases coming on with acute middle ear suppuration, that the middle ear discharge has ceased and the perforation is seen to close. And, because of the fact that the middle ear is not interfered with, after this operation hearing is usually exceedingly good, if not normal, which is a much better result than can be obtained in chronic middle ear disease.

I have recommended to your notice these lines of treatment, and though the first two have their place, yet the last is undoubtedly the best both when looked at on general theoretical surgical grounds and also from its practical results.

Paracentesis treats the causative middle ear suppuration with the idea of aborting a commencing antral infection, and so has only a very limited field. Wilde's incision only evacuates the subperiosteal abscess, a result of the mastoid infection, and does not always prevent extension of the carious process, as was well shown in a case of mine in which a large recent extradural abscess was found six weeks after a Wilde's incision which had apparently drained the abscess satisfactorily.

In chronic cases the objective indications may be tabulated as follows:—

1. With painful inflammatory infiltration of the mastoid coverings, especially when the flow of pus is interfered with and the cause cannot be removed.

2. Spontaneous pain in mastoid, especially with bulging of the posterior superior meatal wall.

3. Remitting attacks of pain with mastoid tenderness.

4. When suppuration is associated with hyperostosis of the meatus which prevents treatment and aids retention of pus.

5. For the cure of a suppurating fistulous track extending into the antrum.

6. Cholesteatoma.

7. Protracted suppuration which continues even after removal of the malleus and uncus, but with no signs of mastoid disease.

8. Caries of tympanic or posterior meatal walls.

9. Tuberculous middle ear suppuration.

10. At the onset of evidences which *favour* intracranial complications, *e.g.*, labyrinthine infection, or facial paralysis.

11. At the first signs of intracranial disease, and as part of the procedure to get rid of this, viz., meningitis serosa, or purulenta, intracranial abscess or sinus thrombosis.

Leaving these conditions for a minute we find there are in the course of chronic suppuration certain subjective indications which suggest that operative interference is advisable; these are persistent or frequently recurring headache, intermittent attacks of or permanent vertigo, and brain symptoms, of which the most characteristic is drowsiness or the onset of unconsciousness.

With regard to persistent or frequently recurring attacks of headache, it must be within the knowledge of everybody that the majority of patients with chronic middle ear suppuration, extending, that is to say, for more than six weeks, have attacks of headache from time to time. People in whom familiarity with chronic middle ear suppuration for some years has produced contempt for its dangers are always willing to attribute these attacks of headache to all sorts of causes, such as indigestion, biliousness, migraine, etc., which probably are not the cause. You find very often that the headache when characteristic of an extending osteitis in the temporal bone or even deeper, is situated in the parietal or occipital region; and you find that this headache is always increased on percussion over the mastoid antrum. Intermittent or permanent attacks of vertigo are valuable when they occur, in that, in the majority of cases, they indicate extension of the purulent process from the middle ear into the labyrinth, by erosion of the horizontal semicircular canal, or extension into the vestibule; and yet in quite a number of cases you find that with the most marked lesions of the labyrinth you have not the slightest evidence of vertigo. I have a specimen here of practically the whole internal ear of a boy who was admitted last year into Naaman ward under Mr. Jacobson, and in whose absence I operated to cure a persistent post-aural suppurating track. As far as my memory goes, and as far as the report indicates, he had never had any evidence of what you might call labyrinthine vertigo. Here I show you the whole of the internal ear; the whole of the labyrinth, with the semicircular canals, and the internal auditory meatus, with the greater part of the facial aqueduct. So you cannot always be sure that where there is no sign of labyrinthine vertigo there is not a lesion of the internal ear.

Another sign that the internal ear was affected would be diminished hearing over the mastoid process of that side as tested by a tuning fork and compared with the sound side. I pointed out at some length in my last lecture that where there is simple middle ear disease and you place a tuning fork on the mastoid process, it is heard longer than over the mastoid of the normal individual. In those cases in which the labyrinth is affected, and the internal ear also, you find that the hearing for the tuning fork over the mastoid process is diminished. That was very well marked in one man who came up to the out-patients with chronic middle ear suppuration, in which the tuning fork test disclosed entire absence of hearing when the fork was placed over the mastoid; here, on operating, is was found that the labyrinth was largely eroded by a chronic ulcerative process which we call cholesteatoma.

With regard to brain symptoms we are to be always on the look out for these in cases of chronic middle ear suppuration whose speech becomes slow, or cerebration retarded, or who seem unusually drowsy. I remember very well some time ago a little girl coming to the out-patient department and she went to sleep while waiting in the room, during the time which is spent by other people in talking to their neighbours. She was admitted into Charity ward and immediately operated upon, as she had other signs of pus in the antrum. She was operated

upon for what was supposed to be an early condition of infection of the mastoid. When the parts were freely exposed, an extra-dural abscess, the size of half-a-crown, was found in the posterior fossa. Another child, also a girl, I remember, who comes under my fifth heading of fistula, emphasizes the same point.

I have referred to her above as having been treated by Wilde's incision for what was apparently an acute abscess—the medical man found evidence of grave bone disease, and two days before I saw her, the child began to vomit and to be drowsy, so much so that she went to sleep while I was obtaining her history. She had a very large extra-dural abscess. So I would ask you to be always on the look out for those signs in chronic middle ear suppuration, indicating, perhaps, that the disease may be spreading deeper, and it is curious—and you will be very much struck with the fact—that in all those cases of, so to speak, "latent" extension of pus from the mastoid antrum, you find very much more at the operation than the symptoms led you to expect.

Let us now return to the objective signs for opening the mastoid process in chronic middle ear suppuration which I have written up under eleven headings. They come naturally into three classes: (A) Those in which you have acute retention of pus in the antrum or mastoid cells in the course of chronic middle ear suppuration. These first class includes my subdivisions 1 to 4, and gives exactly the same symptoms necessitating operation as are found in the acute cases, which I dealt with fully in the first part of this lecture. One point, however, must be made in distinction, these acute exacerbations of chronic disease occur, unlike the primary acute cases, most often in adults; here the outer bony covering of the antrum is much thicker than in children, and therefore the external signs of pus in the bone are usually much less marked and may even be unnoticed for a time; pain is a sign of great value and it is here that the bulging downwards of the postero-superior deep meatal wall is of such value. My fourth subdivision is on the border line of this class. Here you find pus in the middle ear and also hyperostosis or exostosis of the deep meatal wall. With these cases of chronic suppuration in which the meatus is much narrowed, everyone working in the out-patient department is perfectly well acquainted. You will recognise that the meatal periosteum is a continuation of the muco-periosteum of the tympanic cavity and from the latter infection spreads to the former, that is, the osseous meatus is irritated and leads to the formation of new periosteal bone, and so you get bulging of the anterior or posterior wall, narrowing of the meatus, and interference with the discharge externally of pus. Where there is middle ear suppuration *plus* these auditory exostoses, there is, I think, abundant evidence that the pus cannot be freely discharged, and it is in such a case just the one indication in the course of chronic otorrhœa that an operation should be undertaken.

My second class (B) includes the subdivisions 10 to 11; these are the easiest to be dogmatic about, for I think all will agree that operation is here a necessity. I have referred above to the evidences of labyrinthine invasion, and so under subdivision 10, I have only to say a few words on facial paralysis.

You know that this condition usually—though not always—means caries of the facial aqueduct. It may be due simply to inflammatory granulations pressing on the facial nerve where the facial nerve is exposed, not as a result of pathological necrosis or caries of the walls, but exposed naturally, that is to say there is no complete bony facial aqueduct, but in the majority of cases it means that the facial nerve is exposed by caries, and is being gradually inflamed, and finally will be destroyed. The value of the radical mastoid operation in those cases is immense. Just let me recall one case, that of a woman, who had had chronic suppuration sixteen years, and had been attended six weeks for an acute exacerbation of her trouble, during which facial paralysis gradually supervened. When I saw her, her facial paralysis was complete, that is to say, there were signs of infranuclear facial paralysis extending to all the muscles practically between the scalp and the chin on the same side as the otorrhœa. The radical mastoid operation was

performed, the chief indication being the onset and continuance of this facial paralysis; and within three months there was only one muscle she could not move, and that was her frontalis, which has never completely recovered.

The majority of cases of facial paralysis which occur early in middle ear suppuration are tuberculous, and the prognosis in those is entirely different. That, however, I shall come to later.

In the second subdivision (11) of this class, I have only to suggest that after careful examination operative interference should be prompt and thorough, and that the bone wound should be carried widely down to the seat of suspected dural infection in a methodical way, the posterior fossa, with its contained cerebellum and lateral sinus being explored if the middle fossa is found healthy.

But I want to leave this which is too big a question to deal with in the few minutes that remain, and to deal with subdivisions 5, 6, 7, 8 and 9, which can be put in a class (C) and about which we can ask one question, When are we to operate in cases of chronic uncomplicated middle ear suppuration?

Should we operate in chronic middle ear suppuration simply because of its chronicity? In the discussion which took place on this very subject in the Otological Congress in 1899, Macewen, of Glasgow, most distinctly upheld the view that in all cases of chronic middle ear suppuration which did not react to treatment an operation was indicated. The two renowned aurists, Politzer and Luc, who joined Macewan in opening the discussion, held exactly the same views; in fact one might have said that they and the majority of aural surgeons had held and had acted on these views for some years before that date.

There is a time in chronic middle ear suppuration when you cannot hope to cure the condition by means of antiseptics. I think it because some aural surgeons of a past age have said that there is no time when you cannot cure chronic suppuration with antiseptics that so many general surgeons look upon chronic otorrhœa as incurable. The patients go on syringing with antiseptics for years, and they naturally come to regard themselves as incurable. In that way there is a widespread idea that otorrhœa cannot be cured. The reason they cannot be cured in that way is perfectly obvious. You do not try to cure a chronic abscess of the tibia by douching with carbolic acid; you at once appreciate that you should operate. The same holds good exactly in regard to the temporal bone. You are only asked to treat the temporal bone in these chronic cases as you would a chronic abscess in any other bone, namely, by removing the carious parts, for it is because of the bone disease that in these cases the discharge continues.

You naturally ask what evidence is there of this. I regret to say that the sifting of this evidence requires a certain amount of special knowledge, but the signs may be briefly tabulated as follows:—

1. Perforations in Shrapnell's membrane or in the posterior superior segment of the drum, because ante-mortem and post-mortem evidence shows that such perforations usually indicate caries of the malleus or incus.

2. Detection of carious spots with a probe, which are most often found on incus, malleus, posterior deep meatal wall or promontory.

3. Epithelial elements indicating cholesteatoma, or bone granules indicating caries, in the discharge.

4. Frequently recurring granulations.

I think we may certainly say that any middle ear suppuration which is conscientiously treated for three months on sound surgical lines by local antiseptics and, resisting treatment, becomes chronic, even though discharge be slight, and while treatment is continued odourless—I think that such suppuration—primarily for its cure and secondarily to ward off intracranial complications, demands an operation. And, in conclusion, I want to say that in all these chronic cases there is only one operation which should be undertaken, and that is what is called the radical mastoid or Schwartze-Stacke operation. That is to say, whereas in the acute cases you simply open the antrum and mastoid cells and drain behind the ear, in chronic cases, beginning by opening the antrum, you prolong your operation through the bone, so as to include in one cavity the

antrum, the middle ear, and the attic. And if at the end of that you can form a nice smooth cavity in which there is no suspicion anywhere that carious foci are left behind, you will find that procedure will soon be followed by healing and a complete cure of the otorrhœa.

You then sew up the post-aural incision and drain the cavity through the enlarged meatus: this is done by cutting a horizontal V-shaped flap in the cutaneous lining of the posterior meatal wall, which is carried backwards to line the outer and posterior aspect of the new cavity, and is kept in place as healing takes place by carefully adjusted gauze packing. Through this enlarged meatus the whole cavity can be inspected and every part dealt with at each subsequent dressing.

A later modification of the radical mastoid operation has been introduced by a German, Siebenmann, who at the same sitting, having stopped the bleeding and completely smoothed off the whole cavity, took a large number of skin grafts and lined the cavity, because it is found in these radical operations that healing is decidedly slow, which is only to be expected, because it is the kind of thing which goes on in complete epithelialisation of any bony cavity. Therefore Siebenmann took skin grafts according to Thiersch's method, and lined the cavity to hasten healing. This procedure was again modified in the year 1900 by Mr. Ballance, who has simply altered Siebenmann's procedures, in that instead of skin-grafting the cavity at the first operation with multiple grafts, he advised operating a second time after a ten days' interval, and lining the cavity with a single graft.

The experience of many surgeons who have carried out this grafting operation shows that it is a very useful adjunct, but it must be expressly understood that it is not a method of curing chronic suppuration, but only a means of hastening the complete lining of the cavity with epidermis; to cure the disease all carious bone and diseased mucous lining must be removed, otherwise skin grafting will not help to heal the cavity, but the grafts over the remaining carious patches will die and the result will be unsatisfactory.

South African Memorial.

A REVERENT company quietly assembled in the Colonnade of the Hospital on Friday, July 3rd, at 2.15 to witness the unveiling, by General Sir Richard Harrison, G.C.B., C.M.G., of the beautiful Drinking Fountain which has been erected by voluntary subscription to the memory of the Guy's men who fell in the Boer war.

DR. FREDERICK TAYLOR, Chairman of the Memorial Committee, in opening the proceedings, said: The recent war in South Africa, lasting as it did more than two and a half years, though glorious to our arms, was accompanied by numerous fatalities, both from battle and disease. We at Guy's have to mourn the loss of eleven of our old students who were educated here. Some died in battle, the others succumbed to typhoid fever. In order to raise a memorial to them, the sum of £270 was subscribed by old and present Guy's students and their friends, and a monument, by the kind permission of the Governors of Guy's Hospital, is erected in this colonnade. On behalf of the subscribers to that memorial, I have to ask General Sir Richard Harrison, a distinguished officer and a relative of one of our most eminent Treasurers at Guy's, to unveil the monument.

GENERAL SIR RICHARD HARRISON: Dr. Taylor and my friends, it is certainly a most interesting and at the same time a sacred ceremony that I have been called upon to perform to-day. I think I cannot do better than just read you the very short account which has been drawn up of the institution of this memorial. As you have been told, the memorial has been voluntarily subscribed for by Guy's men and their friends. It takes the form of a drinking fountain in coloured and polished marbles, from the design of Mr. Frederick Wheeler, F.R.I.B.A. The fountain has been placed in the colonnade of the Hospital, immediately to the south of the doorway into Astley Cooper ward. It bears the following inscriptions:—

"To the Guy's Men
who died in the South African War.
1899–1902."

and

"Ante Diem Perierunt Sed Militantes
Sed Pro Patria."

and the names of those who have fallen, arranged in the order of the dates at which they entered the hospital as students. The work has been executed by the Coalbrookdale Company, and Messrs. John Daymond & Son.

These are the names of those commemorated:—

THOMAS JONES.—Superintendent of the Welsh Army Hospital. Died at Springfontein.

QUINTEN REID VEITCH.—Major Cape Medical Staff Corps. Died at Cape Town.

CHARLES POPE WALKER.—Major Royal Army Medical Corps. Died in Ladysmith during siege.

FREDERICK MURRAY RUSSELL.—Captain New Zealand Contingent. Killed in action at Rhenoster Kop.

HUGH ARNOLD BRYANT.—Civil Surgeon. Died at Bloomfontein.

FRANCIS WELLFORD. — Surgeon-Captain 7th Imperial Yeomanry. Died of wounds received at the Battle of Vlakfontein.

STANLEY WHICHER.—Civil Surgeon Natal Field Force. Died at Mooi River.

RICHARD TRUMAN FITZ-HUGH.—Civil Surgeon attached to Imperial Yeomanry Hospital, Deelfontein. Died there.

HUGH BERNARD-ONRAET. — Lieutenant Royal Army Medical Corps. Killed at the Battle of Pieter's Hill before the Relief of Ladysmith.

CHARLES BERNARD SELLS.—Surgical Assistant at the Imperial Yeomanry Hospital, Deelfontein, where he died.

LAWSON JERVIS HUGHES.—Mounted Medical Orderly Imperial Yeomanry Field Hospital, killed in action at Kroonstad, on refusing to surrender.

Now, my friends, there are two reasons why memorials of this sort are put up. And one, I think, is that the relatives of those who died may be consoled for the loss of their relatives and friends, for surely it must console them when they find recorded for all time the gallantry and the noble work that was done by them right up to the very end. And the second reason, I think, is to give us who pass by a lesson; for surely it is a lesson to every one of us. We all have a path of duty; it may not be in South Africa, it may not be in anything very heroic; but we all have our path of duty along which we must walk straight, without turning to the right hand or to the left. And we ought to carry on our duty zealously and determinedly, just as our departed friends have done, aye, even to the death. I will now ask the Treasurer and Governors of Guy's Hospital to take charge of this beautiful Memorial, and keep it for ever, to carry out the intention of those who put it here.

Mr. COSMO BONSOR: Dr. Taylor, General Sir Richard Harrison, and my friends, on behalf of His Royal Highness, our President, and the Governors of this Hospital, I accept this memorial to hold it in trust for ever, and I further undertake that a full report of our proceedings to-day shall be entered upon the minutes of the next general Court of Governors, so that no doubt may ever arise as to the object for which this memorial was presented, or as to the intention or the nature of the trust which I now accept on behalf of the Governors. I will now ask the chaplain to lead the way to the chapel.

A very large congregation attended the short service in the chapel, which was choral, and specially arranged to the occasion. The Lesson was taken from the Apocrypha, Wisdom, ii.–iii., 7.

MISS M. ELLIS ROWELL was one of the successful candidates at the recent examinations of the British Gynæcological Society, and gained the two certificates for Gynæcology and Maternity.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Wills Library.

DEAR SIR,—I shall be much obliged if you will insert in the next issue of the GAZETTE, the enclosed letters of thanks from Sir Frederick and Lady Wills. They will I am sure be as much appreciated by Guy's men in general as they have already been by the School Staff, to whom these letters were read, and received with acclamation, at a meeting held yesterday in the Governors' Committee Room.—I remain, yours sincerely,

July 15th, 1903. JOHN FAWCETT, Dean.

DEAR DR. FAWCETT,—Will you accept, and may I also ask you to convey my warmest thanks to the members of the Staff and to the students of Guy's Hospital for the very beautiful brooch they have given me. I admire it extremely, and I shall always value it as a memento of the great Hospital which has done so much for the welfare of humanity—and to which we, as a family, are so much indebted.—Believe me, yours very truly,

July 6th, 1903. ANNE H. WILLS.

DEAR DR. FAWCETT,—May I ask you to convey to the members of the Staff and the students, my own and Lady Wills' warm thanks for the beautiful presents which they so kindly gave us as mementoes of the proceedings of yesterday, and to assure them that we value very highly the kind thought which prompted them to present us with two such beautiful gifts.—With very kind regards, I am, yours sincerely, FREDK. WILLS.

John Fawcett, Esq., M.D., Dean.
July 4th, 1903.

Change of Address.

Dr. K. B. Alexander's address is now Cambridge, East London, Cape Colony.

Dr. E. I. Claxton has moved from 125 to 111, Great Mersey Street, Liverpool.

Dr. Cortis R. Hodgson, from Ashfield to Heronsmere, Dulwich Hill, Sydney, N.S.W.

Dr. Harold Hodgson, from Blisworth to the Lindens, Alresford, Hants.

Dr. W. B. Hope has vacated Caversham Lodge for "The New House," Church Road, Caversham.

A. H. B. Kirkman, F.R.C.S., has left De Aar, and is now R.M.O. at Touws River, Cape Colony.

Dr. W. P. Le Feuvre is R.M.O. at Raylton, Bulawayo, Rhodesia, having left Touws River.

The address of Gerald T. S. Sichel, F.R.C.S. is, The Lawn, Portsmouth Road, Guildford.

Dr. C. S. Ticehurst has moved from Hawkhurst to Havencroft, Point Hill, Playden, Sussex.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Passim.

We publish in this number an exposition, by an occasional correspondent, of the new scheme of composition fees. The strawberry patch principle whereby one gathered as much knowledge as one could on payment of a fixed sum was pleasing if only in its sublime simplicity. It was based, doubtless, on the idle sophistry that all men are equal, and succeeded admirably in the entirely undesired taxation of the worker to the advantage of the drone. A similar evil long oppressed the simple and childlike Clubs' Union until a financier arose and demanded a yearly recompense from each member. So the Medical School, but in a more philanthropic spirit. For the blushing freshman, with maternal kiss still wet upon his cheeks, sees now before him a registrable qualification at a less capital outlay than that demanded from us who write; conditionally only on his exercising a due diligence and qualifying in the five years.

It yet remains to be seen what fate will attend the now familiar test examinations. There are still a few men at Guy's who remember the inception of these instruments of elimination and the righteous indignation which they provoked. The storm raged and abated, and the tests still remained. With an impost on each year's delay, the weak-kneed candidate will have a powerful adjunct in his demand for the privilege of a sporting shot. Every batch of successes contains its percentage of surprises and the rejected of the test examination may reasonably insist on a run for his money. He might even suggest that he was deterred from competing for Conjoint honours through ulterior motives. We congratulate the Medical School on its sound finance, and we await with considerable interest the Battle of the Tests.

We offer our heartiest congratulations to Mr. Langdale and his splendid cricket team. Good scores were put up against St. Thomas's and St. Bart.'s, good clean scores with a respectable margin of safety. But in the final, against St. Mary's, our men opened their shoulders and laid themselves out for a record. Five hundred and seventy-three runs were piled on for six wickets, Wyatt and Morgan, the not outs, contributing 166 and 132 respectively, and Barber 101. St. Mary's could only oppose 250 and 133, so victory was ours by an innings and 189 runs. The result is truly splendid, and aids in marking what is indeed a record year for Guy's. We have already achieved a rare academic success, and can now claim to be the premier athletic hospital of London. And everyone knows that the others do not count.

On Thursday last our Rifle team, which had previously won the Armitage Cup after a grand struggle with Bart.'s and St. Thomas's, brought home for the second time in its existence, the Inter-Hospital Challenge Cup. The shoot is at five-hundred yards, 18in. bull's-eyes, and consists of ten shots. Despite the fact that a brisk shower blurred sights and target, our men averaged 44 points out of 50. French headed the shoot with two points dropped, Robinson coming second with a score of 47. The addition of this cup to our smoking room brings the number of challenge "pots" to nine. We hold the "Rugger" Cup, both "Soccer" Cups, both Cricket Cups, both Shooting Cups, the Cross-Country and the Chess Shields. In our next number we purpose issuing a photographic supplement of these trophies.

We have been requested to call attention once more to the boot nuisance in the Swimming Bath. From motives which suggest themselves at once to the ordinary civilised man, it has been urged upon bathers that their boots should be removed before the actual bathing area is reached. The aim of this regulation is simply to prevent the unnecessary introduction of mud and garden refuse into the bath. Certain unmannerly persons, however, habitually violate this regulation to the discomfort not only of their cleaner brethren, but also of the nursing staff, to whom we are indebted for permission to use the bath. A reasonable proficiency in courtesy

is a profitable asset even to a medical student, and may perhaps be considered to outweigh the physical advantage derived from a hog wash. We hope that this protest will be sufficient, and that the nuisance will not require stringent measures for its abatement.

WHAT would prize-day be without fine weather, without robes, and without speeches? In olden time, before men robed themselves in fine raiment, the chief attraction at a prize-day was a limitless supply of strawberries and cream. With the advent of general hard times, the frugal tea cup replaced its more ambitious partner and prize-days "slumped" heavily. Then an ingenious mind bethought him of robing the men in their purples and scarlets, and once more prize-days boomed. This year was no exception. The day was brilliantly fine; the graduates were in great number, and the æsthetic effect of the robes was pleasing in the extreme. Crowds of people stormed the wards, overflowed into the museums and college, and surged into the Physiological Theatre. There, active stewards had packed the maximum number of spectators into the minimum of space, and in an atmosphere which beggars all description, the good boys were rewarded and the usual speeches delivered.

THE chief characteristic of these speeches, and it was a characteristic they had in common, was their excessive length. The heat and limited air space in the theatre alike cried aloud for a speedy completion of the ceremony, yet was there no curtailment in the proceedings. The speeches had been prepared and were duly delivered, and the audience on the benches shuffled and groaned. It was a mistake and a bad mistake. Much that was said might well have been issued in circular form; much might have been left unsaid. Certainly, considering the heat and the large amount of work in hand, the ornamental portion of the proceedings should have been reduced to a minimum.

PREVIOUS to the distribution of prizes, the procession of Governors had halted awhile at the Wills' Library. There Sir Frederick Wills had unlocked and formally declared open the handsome building which is his gift to the school. Later it was suggested that some regret might be felt by Guy's men at the loss of their old library, but we doubt if the most sentimental could possibly regret for a moment the exchange of the bare uncomfortable old room in the West Quadrangle for the magnificently appointed library in the New Buildings. Sir Frederick Wills has established a claim on the gratitude of Guy's Hospital Medical School which can never be satisfied.

WE hail with pleasure the birth of a new medical paper. The Royal Army Medical Corps has signalised its emancipation from the trammels of red tape by the establishment of a Journal. It would be grossly unfair to criticise the first number of a venture such as this in any but the most favourable spirit. But indeed the production is such that it is but bare justice to congratulate the editor on his work. From the printer's point of view the Journal is admirably produced and is fit to lift its head proudly among the many publications devoted to our profession. We shall look forward with interest to the second number.

THOSE who heard the Dean read his report at the Prize Giving must have been struck by the high efficiency of the London University departments of the school. The last M.B. secured us 16 passes out of 18 candidates, while the massed passes in the Pre. Sci., Inter. M.B., and Final M.B., amounted to 50 out of 57 aspirants. This abnormally high percentage is not due to a lowering of the University standard but solely to the merit of our own candidates. In the above mentioned M.B. Examination where we obtained 16 passes out of 18, or 89 per cent., the other schools together only obtained 35 passes out of their 67 applicants; that is, a percentage of 48. Comment is needless.

THE death of William Ernest Henley removes from the list of English poets the only man who sang of hospital life. Gazing from the

"The South African Memorial."

standpoint which we find it impossible to attain, the standpoint of an educated and observant, but essentially lay patient, he clothed his impressions of ward and nurse, of theatre and surgeon in the vivid, pregnant language of a true poet. His description of the ward—

"The gaunt brown walls
Look infinite in their decent meanness.
There is nothing of home in the noisy kettle,
The fulsome fire."

And of his anæsthetization—

"Then they bid you close your eyelids.

* * * * *

And you gasp, and reel, and shudder
In a rushing, swaying rapture,
While the voices at your elbow
Fade—receding—fainter—farther."

(From *In Hospital.*)

are pregnant with poetic feeling, and intensely real. His death seems almost in the light of a personal loss to us, who, living in hospital can best appreciate the absolute faithfulness of his pen.

Dr. Taylor has re-published a paper read by him before the East Surrey District of the S.E. Branch of the British Medical Association in March last, on the Treatment of Chlorosis. The point which he emphasises most strongly in this monograph is absolute and complete physiological rest. He admits the time-honoured exhibition of aperients and iron, but strongly deprecates that therapeutic agent "fresh air," when obtained through the medium of exercise. No doubt there is a strong tendency nowadays to reduce the period of complete rest after medical and surgical treatment, to a dangerous minimum. The exigencies of hospital life to a large extent account for this, while the demands of the patient help still further to reduce the period of convalescence. Dr. Taylor's paper will have served one good purpose if it merely makes the practitioner of medicine pause when he is giving permission to his patient to restart work.

We publish with this number a photograph of the South African Memorial which was unveiled by General Sir Richard Harrison on Prize-day.

Originally suggested by the Gazette, the project was at once taken up by Guy's men, past and present, and discussed from every conceivable point of view. Much correspondence, many debates, and a great mass of argument arose, and in the end the present memorial fountain was conceived by the subscribers' own committee and executed according to that committees' plans. And with the unveiling of the memorial our self-imposed task ceases, and we can once more sink into the modest retirement that is our delight.

Nursing News.

Matron's Office.

On Wednesday, July 1st, the Medical wards changed over, and the new ward, Esther, was opened. The men's Medical wards Stephen and Philip have been transferred to Old Mary and Mary wards, (the latter will in future be known as Addison), and Mary to Philip; the new female Medical ward being what was known as Stephen. Sisters Philip and Stephen have gone over with their patients; Sister Mary has been transferred to Esther, and Sister Theresa, the night sister, has been appointed sister of Mary ward.

On June 10th, Nurse Cope, head nurse in Mary, left the hospital on completion of her training, and Probationer Hasler was appointed to succeed her as head nurse.

On June 13th, Nurse Walker, head nurse in John, left the hospital on completion of her three years' training.

On June 15th, Nurse Carter, head nurse in Luke, left the hospital on completion of her three years' training to take up her duties on the private nursing staff. Probationer F. Edmonds has been appointed to succeed her as head nurse in Luke.

On June 19th, Probationer Spink was appointed head nurse in Victoria ward.

On June 22nd, Nurse Russell left the hospital on completion of her three years' training, to take up work in America for some months, and Probationer Boodle has been appointed to succeed her as head nurse in Patience ward.

On July 2nd, the following appointments were made—Probationer Thorpe, head nurse in the Out-patients Department, Probationer Stanton, head nurse in Addison, Probationers Coward, Anderton and Cornwell, head nurses in Mary ward, and Probationer M. Brown, head nurse in Stephen ward.

Guy's Hospital.

OPENING OF THE WILLS LIBRARY AND DISTRIBUTION OF PRIZES.

Friday, July 3rd, 1903.

THE large Physiological Theatre had its capacity taxed to the utmost for this important event, which was indeed a brilliant function in every respect, its success being aided by the perfect weather which prevailed.

At 2.50 the Governors and Staff of the Medical School assembled in the Court Room to meet Sir Frederick Wills, Bart., M.P., and to conduct him to the library which has received his name. Sir Frederick then formally declared the library open, and the company proceeded to the large new theatre, where the chair was occupied by the Treasurer, Mr. Cosmo Bonsor.

The CHAIRMAN: I call upon the Dean to make his statement.

The DEAN (Dr. Fawcett) then read his statement.

The CHAIRMAN:—Sir Frederick Wills, Sir Richard Harrison, ladies and gentlemen, it has now become a sort of recognised procedure that after the Dean has made his statement the Treasurer of Guy's Hospital must say something about the work which has gone on during the past year. But I hope on this occasion, as Sir Frederick Wills is good enough to be here, you will pardon me if I do not go into anything like detail. After the very exhaustive report of the Dean, dealing with practically everything of interest that has taken place during the last twelve months, it would be superfluous of me to reiterate the story. But I hope you will accept my statement that the hospital to-day is doing a greater work than it ever did in its duty towards the sick and suffering of London, that the school has had a record year, that the honours which Sir Frederick Wills is going to distribute almost immediately are only a very small modicum of the honours the school has won during the past year, and that it is, with all its great adjuncts which have been added during the past year, gaining in popularity, and is, I believe the premier medical school, not only in London, but in the world. (Applause.) To-day I would rather deal with the questions of interest which have happened within almost the last few days. The Dean rightly alluded to the honors which have fallen upon the members of Guy's staff. May I allude to the honour which the King has bestowed upon my friend on the left, General Sir Richard Harrison, on his retirement from active service? (Applause.) I think it is for four generations that General Sir Richard Harrison has been closely connected with Guy's Hospital, and the work which he has been good enough to perform to-day is added to the record which we all feel of gratitude to his family. The Dean naturally alluded to the honours of which I may say we all are particularly proud, namely, those given to Dr. Perry and to Mr. Fripp. He alluded to the fact that their work as members of the Advisory Committee on the reorganisation of military hospitals had probably led to this honour. Gentlemen, it is a great pride to us who work with them to think that Guy's Hospital was singled out for choosing the men who were practically to reorganise the great military hospitals of the country. (Applause.) The Dean alluded to the fact that they were members of the Advisory Committee, and I think I may be allowed to cap what the Dean said by saying that that Advisory Committee has almost ceased to exist, and that an organised committee has been elected in perpetuity. And when I tell you that Sir Cooper Perry has been chosen as the chairman of that committee I think you will appreciate the honor that has been done to him and to Guy's Hospital. (Applause.) And when I further add the fact that I believe it was Sir Frederick Treves, who is also on that committee, who proposed that Sir Cooper Perry should be the chairman, you will understand that the honour is all the greater. To-day Sir Richard Harrison has been good enough to unveil the beautiful memorial in the colonnade erected by the subscriptions of Guy's men and their friends to those past students of Guy's who fell in the South African war. Gentlemen, it is a remarkable fact that whether it is in sorrow or in congratulation, all Guy's men come together on an occasion like this. The list of subscribers is long, and the list of sympathisers is longer, and it is a very remarkable thing to think that they have chosen Guy's Hospital, their own alma mater, in which to erect this memorial. I have to-day, on behalf of His Royal Highness the President and the Governors of the hospital, accepted the solemn trust of maintaining the memorial for ever, and of seeing that the object for which the subscriptions were given, and the intention of the subscribers, should be kept in perpetuity by being placed upon the minutes of the Governors. Then again, to go to one other subject of interest to which the Dean has also alluded, namely, the opening of the Wills Library by Sir Frederick Wills, the Dean very naturally said that the School had already passed a vote of thanks for the great munificence of Sir Frederick Wills. I anticipate that possibly there may be some of our old Guy's friends who will heave a sigh of sentiment over the old library, which is going to disappear, and which will shortly become a part of the wards of the hospital. I recollect very well when the old stones in the colonnade were taken up, that an old Guy's man showed such affection for them that he was anxious to decorate his suburban villa with some of them. And when I tell them that possibly some of our old friends who are here to-day will sigh when they think that the library in which so many eminent men have studied is going to cease to be a library, I am confident that when they view the Wills Library that sigh will be turned into joy that future generations are to have such a well-appointed and such a charming building in which to continue the traditions of medical research and study in Guy's Hospital. Sir Frederick Wills, I have been asked to convey to you the thanks, not only of His Royal

Highness the President, and the Governors of the hospital, but the whole of our medical staff and students. I have been asked to present you, Sir Frederick Wills, with the key with which you will be good enough to unlock that library. I have been asked by our staff of students to present to Lady Wills, who I regret to say is unavoidably absent—so I presume I may give it to Miss Wills—a small souvenir of their good feelings; it is a small copy of the key which you have, sir, and a recognition, to a certain extent of the great work which she has done. (Loud applause.) That work will live. The Wills Library will be known for many generations to come, and the records of Guy's Hospital have already proved of inestimable service to the medical and surgical world. In the future, at any rate, they will rest in a home worthy of Guy's Hospital, and worthy of the great man its founder. I will now call upon Sir Frederick Wills to perform the object with which we have met to-day, namely, to give away the prizes to the successful students. (Loud applause.)

Sir Frederick Wills then distributed the prizes amid much enthusiasm. The following is a list of medallists and prizemen:—

Open Scholarships in Arts.—Thomas Stansfield, Reading School, £100. Philip Hirschbein, Owen's School, Islington, £50. Harry Archibald Sanford, Roan's School, Greenwich, Certificate. Edward Leslie Martyn Lobb, Rydal Mount School, Certificate.

Open Scholarships in Science.—Thomas Edmund Ashdown Carr, Guy's Hospital, £150. Kenelm Hutchinson Digby, Guy's Hospital, £60. George French Stebbing, Guy's Hospital, Certificate.

Scholarship for University Students.—Hector Charles Cameron, St. John's College, Cambridge, Ronald Edgar French, King's College, Cambridge, equal £25 each. Arthur Hallowes Miller, Trinity College, Cambridge, Certificate.

Open Scholarships in Dental Mechanics.—October, 1902, Albert Harris, £30; May, 1903, Herbert Snell, £20

Junior Proficiency Prizes.—Herbert Orpe Brookhouse, £20. George Cockcroft, £15. Thomas Bramley Layton, £10.

The Michael Harris Prize for Anatomy.—Herbert Orpe Brookhouse, George Cockcroft, equal £5 each. Thomas Bramley Layton, Certificate.

The Wooldridge Memorial Prize for Physiology.—Herbert Orpe Brookhouse, £10. George Cockcroft, Certificate. Thomas Bramley Layton, Certificate.

The Hilton Prize for Dissections (1902).—Arthur Boniface O'Brien, £3. Howard Vincent Mitchell, £2.

The Arthur Durham Prizes for Dissection.—First Year's Students.—Ernest William Giesen, £5. Kenelm Hutchinson Digby, Certificate. Senior Students.—William Henry Miller, £15. William Henry Trethowan, Certificate. Patrick Francis McEvedy, Certificate.

Dental Prizes.—First Year's Students.—Arthur Alan Forty, £10. Herbert Poyton, Certificate. Second Year's Students.—Richard Roberts, £15. Albert Edgar Dunkin Prideaux, Certificate.

Practical Dentistry Prize.—Albert Edgar Dunkin Prideaux, £10. Richard Roberts, Certificate.

The Treasurer's Gold Medal for Clinical Medicine.—Neville Ivens Spriggs, Henry Francis Bell Walker, Proxime Accessit.

The Treasurer's Gold Medal for Clinical Surgery.—Gerald Charles Frederick Robinson.

The Golding-Bird Gold Medal and Scholarship in Bacteriology.—Neville Ivens Spriggs, £20.

Sir Frederick Wills: Mr. Treasurer, ladies and gentlemen, I may say, in the first place, that I felt it an exceedingly great honour to be asked to perform this function which we have just gone through to-day. And when I remember that last year I was preceded by His Royal Highness the President of this hospital you can imagine that I felt the honour to be all the greater. I am very glad to see—indeed we are all glad to see—that the Prince of Wales is endeavouring to follow in the steps of his father, our beloved King, and his grandfather, the Prince Consort, in doing those works of charity, those deeds that are for the good of our country at large, of which his grandfather and his father have set such a noble example. I have, in the second place, the very great pleasure of congratulating the prizemen whom we have seen before us to-day on the prizes which they have succeeded in getting by dint of hard work and careful study. I hope it will be an encouragement to them to persevere in the same way during the rest of their lives, so that they may become even more distinguished members of Guy's than they are at the present time—distinguished as they now are. I would offer my condolence to those of our students who very nearly won the prizes—(Applause)—who were within an ace of getting them. I hope they will persevere, and that perhaps next year they, too, or many of them, may be in the proud position that these gentlemen are in now to whom I have had the very great pleasure of handing the prizes they have won. Well, there are many distinguished students at this hospital, and though it would be invidious to mention others I would like to mention the name of Mr. O'Brien—(Applause)—who is a gentleman who came to this hospital from New Zealand. And I am glad to think that he is not alone; I believe there are two other students here from New Zealand also. To Mr. O'Brien I have had the pleasure of handing two gold medals, one for anatomy, and the other for organic chemistry, and I must congratulate him very sincerely, because it is a very rare thing for a man to win one gold medal in such a medical school as this; but for a man to come and take two gold medals must I am sure be a very rare occurrence. I have to congratulate the school on the fact that two Guy's men have been successful in securing the very proud degree of Doctor of Science of the London University—(Applause),—Dr. Hopkins and Dr. Wade. Ladies and gentlemen, that examination is really a very formidable one to go through, and no man could possibly succeed in becoming a Doctor of Science unless he had brilliant abilities, and not only that, but also unless he had given hard work to the subjects he had to study.

Now, ladies and gentlemen, I want to touch on another question, which does not exactly refer to the students themselves, but now I have an opportunity of speaking not only to you who are present but, peradventure to a few others, may be, through the medium of the Press, I should like to just allude to the necessity that this medical school, and all medical schools, lie under with regard to endowments. I believe that it is a very generally received idea, in so far as people think of the medical schools at all, that they are not matters of very great importance, that if a man is asked to subscribe to a hospital, the very first thing he thinks of, and probably the only thing he thinks of, is that by giving a donation to the hospital he is doing something for the poor and those who are in trouble in consequence of disease and ill-health. But they happen to forget, I suspect, that no good hospital can possibly exist without a good medical school, because it is practically the medical school which feeds the hospital with medical men, who have to come on and take the active work of the hospital. Moreover, no good medical school can possibly exist without a good hospital at the back. But I am sure we, the general public, are under a great debt of obligation not only to the hospital itself, but to the medical school connected with the hospital, because it is in the medical school that great discoveries are made, and that is impossible to be carried on without endowment. I am afraid this medical school of ours here has not that amount of support by way of endowment that it ought to have, and which it would have if the public only knew the necessity of such a thing. This great medical school of ours—for is a great school—has, I am told, some five hundred students. I suppose it would take two or three colleges at Cambridge—barring Trinity, of course—to make such a school as that. It seems impossible that a great school with five hundred students could possibly be carried on without endowments. How could we have had Oxford or Cambridge University, or Owens College, Manchester, or Mason's College, or any of those great institutions, unless philanthropic men had come forward in days gone by and endowed these colleges? And how can this medical school of ours expect to be flourishing unless some of our philanthropic friends who are blessed not only with philanthropic hearts but with a good exchequer, come forward and realise the necessities of the school, and help to found endowments for scholarships and studentships? I do trust that if these words fall under the eyes of any such as I have described, that some may come to this school in which we are all so much interested (Applause). Our indefatigable friend, the Treasurer, tells us that he wants just a small sum—I think he mentioned £180,000—not to-day, and of course it would be a mere bagatelle. So if any gentleman knows a friend who has £180,000 which he does not quite know what to do with, he might mention that Mr. Cosmo Bonsor would be very glad to relieve him of it, because there are many things here which require to be done, and £180,000 would come in very conveniently and would relieve Mr. Cosmo Bonsor's mind. (Hear, hear and applause). He says "Hear, hear," and by that I suppose he means he would like to see the money here. (Laughter). But there is one little thing that is very near our Treasurer's heart, and that is this: he wants very much to see a new museum. The governors have gone so far, I understand, as to put in the foundation. But they just want a trifle of £5,000 to build this museum. You will all admit that a medical school is not complete until it has a good museum. I think I am right in saying you have a good many objects already which would look very well in a museum and be very interesting. But I may point out this one thing, and I hope our friends of the Press will make a note of it, and that is, that although this building can be erected at the present time for £5,000, if any great delay occurs it will cost a great deal more. And for this simple reason, that at present the approach to the piece of land on which this museum should be built is open; but I am given to understand that that is because the piece of land which joins it is not yet occupied. I am afraid it has been sold by the people, not our hospital, and that in a very short time, probably, the roadway there will be cut off. Therefore, it stands to reason that it would cost a great deal more to build a museum if that road were closed than if it were done at once. As soon as some philanthropic gentleman comes forward and does it I am sure the happier our friend the Treasurer will be. We have had many benefactors of late to this school, and I should like to mention the names of one or two, and I am sure you will bear with me if I do. I should like to mention Mr. Raphael, who has given such a munificent sum towards the nurses' home. By that means he has conferred a great boon on the nurses of this hospital, a boon which I am sure is highly appreciated by the nurses who enjoy it. And I should like also to mention Sir Cameron Gull, who has benefited the school by endowing a studentship in the college. There is a gentleman here who has also been a great benefactor, I allude to Mr. Gordon, the gentleman who built the Gordon Laboratory and endowed it. Well, ladies and gentlemen, there is no doubt whatever that the school and the hospital are inseparably connected. As I said before, we cannot have a good school without a good hospital, and you cannot have a good hospital without a good school; and therefore it seems quite natural that, going from the school for a moment, I should pass on to the hospital and thank very heartily Mr. Beerbohm Tree for his great efforts the other day in giving a performance at his theatre on behalf of Guy's Hospital—(loud applause),—by which a sum of two thousand guineas was realised and handed over to the Treasurer. When Mr. Tree was asked what the expenses were he said, "Oh, there are no expenses." Now, I say that we are under a great debt of obligation, not only as a hospital, but as a school in connection with the hospital, to Mr. Beerbohm Tree for his great munificence and kindness in helping us in this way. I am very glad to hear that Mr. Beerbohm Tree is now one of our colleagues; he has been elected a governor of this hospital. (Applause). I may say that that is a compliment which he himself will very

highly appreciate. Our Dean has already alluded to the honours which His Most Gracious Majesty has been pleased to confer—I was going to say upon the hospital—but upon our friends, Sir Cooper Perry and Sir Alfred Fripp, and therefore I think I may be pardoned if I just mention their names again, because it gave me, as it has given all of us, the very greatest pleasure to see their names in the list of Birthday Honours. I am sure those gentlemen have deserved that recognition from His Majesty which, I am sure, he has been exceedingly glad to give. I would like also to allude to Dr. Pye-Smith, as our Dean has already referred to his appointment as Vice-Chancellor of London University. That is an honour any man might well be proud of, and I think I may say we at Guy's are exceedingly proud to think that Dr. Pye-Smith has been appointed to such a very distinguished position, a position which he is so admirably qualified to fill. (Applause.) I should like to allude to one more point with regard to Sir Cooper Perry, and that is, he is Chairman of the permanent Board in charge of the administration of Military Hospitals. That is a great tribute to Dr. Perry's ability. (Applause.) I know it is a warm day, and it is particularly warm in this theatre. I am aware of it myself, and I suspect most ladies and gentlemen are aware of it too, and that this day has been appointed not only for the presentation of prizes, but also as a garden party. I believe there are probably many ladies outside who are unable to get here and who are looking forward to your presence, and I think I should best subserve your wishes if I bring my remarks to a conclusion by saying with how great a pleasure I have performed what function I have had to carry out here, and how proud I am to belong to Guy's Hospital. (Loud applause.)

The CHAIRMAN: I am sure we should be glad to hear a few words from General Sir Richard Harrison. (Applause.)

Sir RICHARD HARRISON, G.C.B., C.M.G.: Sir Frederick Wills, Mr. Cosmo Bonsor, ladies and gentlemen. The task, or rather pleasure, which is put before me now is to acquaint you with the fact that we have unveiled in the hospital the South African Memorial. I suppose having said that I have said all that I ought to say, but I do not think I can sit down at once without telling you very briefly—and I do not propose to keep you more than a very few minutes—what this memorial which we have unveiled is. It was subscribed for by Guy's men and their friends, and it takes the form of a drinking fountain in polished marble, bearing gun metal inscriptions. You can see it when you go outside. It was designed, and I think exceeding well, by Mr. Frederick Wheeler, and it is an exceedingly beautiful memorial. It has been placed in the hospital colonnade, immediately to the south of the doorway into the Astley Cooper ward. It bears the following inscription: "To the Guy s Men who died in the South African War. 1899–1901," and "Ante Diem Perierunt Sed Militantes Sed Pro Patria." I read the names out when we unveiled the memorial and I need not do so again now, but I may say that as over one hundred young men from Guy's were employed in the late war (applause) the number who have given up their lives bears a very large proportion to the numbers who were so engaged. It was as much as 10 per cent., and that is a very large proportion for any regiment employed in that war. I thought I had now said enough, but a little bird told me that you would be pleased if I said a few words in reference to the relations of the medical profession to the army—I presume the British army. That is a very large subject. Fortunately for you I was only informed of the fact that such a large task would fall upon me a short time ago. It requires deep research, research into history, and I am quite sure that if I had been told that I should have had to speak to you on such a subject, I should have buried myself in some attic or some vault and should have gone thoroughly into the historical question and then sat down and compiled a very stupendous essay. You have been relieved of that and you will be able to go and enjoy the beautiful air outside with some comfort, in I hope a few minutes' time. But as I have been asked to say a word or two, I must tell you what has been my own experience in this connection. When I first joined the British army, which I am sorry to say is a good many years ago, in every regiment there was an officer, a medical officer, who wore the same dress as the other officers of the regiment; he was exactly the same as all the others; you could not tell one from the other. He took great interest in the history of the regiment and its traditions, and he knew all the officers and a great many of the men. And very often, I must tell you, he used to manage the men, and he did it very well. He always gave a considerable tone to the conversation, which, when he was present, was sometimes diverted from the perpetual military element which existed, and exists very much in regiments. I must tell you that this gentleman had not only the duty of curing the sick and wounded, but his business was to prevent disease. He was able to go to the commanding officer and make suggestions, and do everything that he could to prevent disease, and in that way I always thought he did a very good work. However, there were good people about who said this medical officer had got nothing to do; he is not much use. And so when one of those waves of retrenchment came upon the government which you have heard of occasionally, a good many institutions that had sprung up since the Peninsular war had to go; and amongst those people who went was what we called the army doctor, that is, the regimental officer; and in his place a staff corps was established, staff medical officers, and certain prominent staff men under them who did duty in stations and in hospitals, but had nothing actually to do with the regiment. This went on for a good many years, and it went on with a fair amount of success. The wars in which we were engaged were not large, and of course there were a great many excellent officers and excellent men among them. But when we came to the great South African war, which employed a large number of troops, and when the stress

came upon us and we found we had to send out to that war not one, not one-and-a-half or two army corps, which was all that we had in England, but when we had to send out five times as many troops as any government had ever provided for, it was a natural thing that a good many of the departments were not able to do the whole of the work that they were supposed to do. And among others there was the medical department, which no doubt broke down. I am not going to enter into the question of the why or the wherefore. There is a Royal Commission sitting upon that question now, and no doubt it will give you an excellent report, and they will explain to you the whole reason of the breakdown. But before the breakdown occurred—because we saw it coming—what did we do? We did, I think, the best thing that could possibly have been done, we appealed to the country, and, ladies and gentlemen, right nobly has England answered to that appeal. (Applause) No doubt they were prepared to a certain extent by the great volunteer movement, which, as you know employed, not very earnestly, but they employed a great number of medical officers, and England was also prepared by that marvellous organization that exists now, the Society of St. John of Jerusalem, the ambulance corps, of which I am a member. That ambulance corps has been going on for a good many years, and is organised all through England and the whole of the States, and it is a wonderful organisation. The appeal was answered by men going out from all the great hospitals of England, and among others, from Guy's. And now we come to the memorial. Guy's was not behindhand. Guy's sent out her men to do work in every sort of capacity out there. The situation was met, and at the end of the war the medical organisation that exists—and I think I am not wrong in saying so—was infinitely better than the medical organisation with which we started. One thing more before I s t down if you will allow me, and that is with regard to the future of the connection of the medical profession with the British army. No doubt the number of excellent officers, gentlemen and also ladies, who went out to South Africa, and most of whom I am glad to say have come back again, has let the light in most thoroughly upon what we may call the Army methods, and I hope that light may be of enormous benefit to the Army Medical D epart ment. I feel sure that it will be, because, as you have already heard, our Secretary of State, who has taken a very great interest in the subject, has appointed an Advisory Board of distinguished medical and other gentlemen, to advise him on what is best to be done for the Army Medical Service. And on that board you have Guy's very strongly represented by two men, whom I may still call for the last time my friends, Dr. Perry and Mr. Fripp—I hope Lady Perry and Lady Fripp will pardon me for the liberty, because they have not yet had the King's sword placed across their backs—who are also two of the strongest men on that committee, and I feel sure that we may look with hope to the future; and we may then feel and rest assured that those whose names we have written on that memorial in the colonnade outside who died in South Africa, and whose names are also recorded in other memorials in other parts of the country, will not have shed their blood in vain. (Cheers.)

Dr. FREDERICK TAYLOR: ladies and gentlemen, I am very sorry I cannot entirely endorse the suggestion of Sir Frederick Wills, supported by Sir Richard Harrison, that you should immediately go out and enjoy the attractions on the other side. I may point out to you that it is not yet quite tea time, and in the interval that remains I must ask you to accord a very cordial vote of thanks to Sir Frederick Wills for presiding at this function to-day, and for all that he has done and shown his willingness to do. (Applause.) Sir Frederick Wills, we know, has been a governor of the hospital for a few years. He has done, I think, as you have already heard to-day, many benefactions to the hospital and the school. We have to thank him on the present occasion for coming here and presenting the prizes to the successful candidates. We have to thank him for the able and interesting address that he gave us afterwards, and I must express again the very cordial thanks we feel, and which I hope you will express again, for the munificient gift of £1,000 which he has made in order to bring about our introduction to the library which has been waiting for us for some time. Sir Frederick Wills has not provided all the bricks and mortar, though his gift has helped us to make the conversion which was necessary before the library could be utilized. He has not provided books, but he has provided all those really handsome and excessively complete fittings that I hope you will all go and see after this meeting; he has given the chairs and tables and electric lighting fittings, and everything that is necessary to complete the library. I do not know that I feel called upon on this occasion in connection with that library, to impress upon you the value of a library—probably all of you know it—or the value of books. I need not make a list of the "Hundred Best Books," nor need I discuss the question of how far it is the part of a good citizen to welcome a substantial addition to the bricks in order to provide a new public library. That is a question which is discussible. But for all our students a library is necessary. These public libraries to which I referred are utilized no doubt very largely for what I may call recreational purposes, that is to say, that a great number of the readers do not spend a great deal of time in those libraries in the pursuit of that occupation by which they get their living. But the library we have to do with now is a purely scientific library; it is a library consisting of books on medicine and surgery, and all the allied sciences. Of course in that library you will not find even the Hundred Best Books; you will not find Marcus Aurelius, nor Confuscius, nor even Dickens' novels, or Gibbons' Decline and Fall, nor the plays of Shakespeare; you will only find those books which one has to use for science. Lord Avebury, in his interesting work on "The Pleasures of Life," says the following, partly quoting from other sources, "Comfort and consolation, refreshment and happiness are, it may be, found in this library by anyone

who shall bring the golden key and unlock the silent door" (&c. to "Eden.") I am not sure whether those whose duty leads them to occupy the Wills Library will exactly regard it as a paradise. They may indeed comfort and console themselves with the reflection that at the end of every week they know a little more than they did at the beginning; they may refresh themselves with the lines *which may slip from them; and they may be happy in* the consciousness and the reflection that little by little they gradually increase the very small proportion which the knowledge they have bears to the knowledge they hope some day to get. But the library in that connection is a real necessity; the books must be there, and they must he read by the students. I may just make a remark as to the advantage of reading a book, because after all, in associations of this kind with other students there is sometimes a small proportion of them which does not believe in the absolute necessity of undue application to the pages of scientific literature. The knowledge has to be got, by hook or by crook, generally by hook; and why neglect the obvious means of obtaining this knowledge? Why neglect the advantage of the accumulated experience of others, and the expression of their mature ideas after much study? It is quite certain that there is much knowledge that cannot be acquired in any other way. I think we may say that the day has gone by when a student may acquire the necessary knowledge of his science by listening to lectures and attending classes, and walking the wards. I may refer, however, just to two of the objections that are sometimes made to reading. It is sometimes said that the practical man, as he is called—I am not sure whether a practical man means a handy man, but I think it does—that the practical man is a better man than the bookworm. Another thing which is said is, If you want to learn anything thoroughly you should go to the Book of Nature. With regard to the practical man, I think experience shows us that, firstly, the reading man is not prevented from being practical, and that there is time for both practical work and reading, and that really one has a knowledge of men who have done both those branches of work most thoroughly. And again, it is obvious there must be lots of work which has to be done a knowledge of which has to be obtained from books which cannot be got otherwise in the short period allotted for study. I might allude to the very striking instances that we have every now and then of the illustration which is afforded by the result of the work of foreign observers being conveyed to us, and our acquisition of this knowledge of the recognition and treatment of disease. With regard to the Book of Nature, I think it is an unfortunate suggestion, at any rate it is not absolutely correct. The Book of Nature is, I believe, for the most part a closed, a sealed book, one which is bound by clasps of adamant requiring a key to open it which is much more expensive than the key which has been presented to-day to Sir Frederick Wills, or that which Miss Wills has accepted on behalf of Lady Wills in the regrettable absence of her ladyship. The practical man has nature before him, what does he know about it? He wants many books and much information to benefit thereby. We want a key which will unseal the book of cancer. That has cost some £60,000 already and much more is wanted. We have the assurance that this book will be opened this decade, or next decade, or the decade after that. Let us hope it will be opened very much sooner. (Hear, hear.) *So the Book of Nature is one which can only be* got at by very much study of other books. Well, ladies and gentlemen, the Book of Nature will not obviate the necessity of having a Wills Library, and we are much obliged to Sir Frederick Wills for providing us with the means of helping our students to that knowledge which is necessary for them as a part of their profession. (Loud applause.) I have also to ask you to accord a vote of thanks to General Sir Richard Harrison for his kindness in coming before you to day and unveiling the memorial, and speaking as he has done. He is a distinguished officer, who has served all over the world for nearly fifty years, in some of the most trying campaigns in which the British Army has been engaged—the Crimean war, the Indian Mutiny, in Egypt, in South Africa, and recently in Gibraltar at the fortifications there. There have not been many operations of recent years in which General Harrison has not been engaged. He is a relative of one of our most distinguished treasurers; we have had two treasurers named Harrison. Mr. Harrison, senior, was treasurer for nine years, but the second Mr. Harrison was treasurer for fifty-one years, and he conducted the affairs of the hospital so well that he has long been known as King Harrison. Although he was somewhat despotic in his management, he did the work remarkably well. At that time it was not separated from St. Thomas's Hospital school, and it was under Mr. Harrison that all fresh arrangements became necessary, when it was converted to a home school. We have to thank Sir Richard Harrison for the remarks he has made, especially on the Army Medical Department. He said that in order to say very much he would have to bury himself in an attic or a vault. I should have thought he would have buried himself in the Wills Library. I have to ask you to heartily pass this vote of thanks. (Loud applause.)

Mr. CLEMENT LUCAS: Mr. Cosmo Bonsor, ladies and gentlemen, I am sure you will allow me, in the shortest possible speech, to second the vote of thanks which my colleague, Dr. Taylor, so ably proposed to Sir Frederick Wills for the munificent gift which he has made to this School, and for his kindness in giving away these prizes; also to Sir Richard Harrison for the melancholy duty which he has undertaken in unveiling that Memorial, which we hope will be handed down for all time to tell of the great deeds which have been done by the students of this hospital. I shall not detain you any longer, but will ask you to give a most cordial vote of thanks to these most distinguished governors for the part they have taken. (Loud applause.)

The proceedings in the theatre then terminated, and the company joined the other guests in the Park where

the Band of H.M.'s 1st Life Guards rendered the following programme (by kind permission of Colonel Calley, M.V.O. :—March, "Duke Albert" (Schneider); Overture, "Banditen Strieche" (Suppe); Valse, "Luna" (Lincke); Selection, "The Girl from Kay's" (Caryll); Song, "The Children's Home" (Cowen); Gavotte, "Heimlich Liebe" Burald; Fanfare Militaire (Lehnhardt; Selection, "Three Little Maids" (Rubens); Duet, "Excelsior" (Balfe); Morceau Mignon, "Salut d'Amour" (Elgar); Selection, "The Fortune Teller" (Victor Herbert); Finale from "Barbe Bleue" (Offenbach).

"God Save the King."

Notices.

INDIAN MEDICAL SERVICE.

INDIAN OFFICE,
1st May, 1903.

An examination for not less than 16 Commissions in His Majesty's Indian Medical Service will be held in London on 3rd August, 1903, and four following days.

Copies of the Regulations for the examination, together with information regarding the pay, retired pay, &c., of Indian Medical Officers, can be obtained on application to the Military Secretary, Indian Office, London, S.W., to whom applications for admission to the examination, together with the necessary Certificates, should be sent not later than 23rd July, 1903.

E. STEDMAN, *Major-General*,
Military Secretary.

HIS MAJESTY'S INDIAN MEDICAL SERVICE.

A competitive examination for not less than sixteen commissions in His Majesty's Indian Medical Service will be held at the Examination Hall, Victoria Embankment, London, commencing Monday, 3rd August, 1903.

Applications for the regulations for admission to His Majesty's Indian Medical Service should be addressed to the Under Secretary of State for India, India Office, Whitehall, S.W.

PROGRAMME OF EXAMINATION.

Professor T. Clifford Allbutt, M.D., F.R.S., in Medicine and Therapeutics.

Mr. Howard Marsh, F.R.C.S., in Surgery and Diseases of the Eye.

Professor D. J. Cunningham, M.D., F.R.S., in Applied Anatomy and Physiology.

Professor Calder Leith, M.B., B.Sc., F.R.C.P.E., in Pathology and Bacteriology.

Dr. Milne Murray, F.R.C.P.E., F.R.S.E., in Midwifery, Diseases of Women and Children.

Professor Ralph Stockman, M.D., F.R.S.E., in Chemistry, Pharmacy, Botany and Zoology. (Candidates have the option between Botany and Zoology).

THE WRITTEN EXAMINATION.

Three questions will be given in each subject, all to be answered.

Two hours will be allowed for each paper.

Examiners will attend whilst their papers are being answered, and will communicate to all the candidates any explanation asked.

3rd August.

Paper in Surgery and Diseases of the Eye, from 9 to 11 a.m.

Paper in Medicine and Therapeutics, from 11.30 a.m. to 1.30 p.m.

Paper in Pathology and Bacteriology, from 2.30 to 4.30 p.m.

4th August.

Paper in Applied Anatomy and Physiology, from 9 to 11 a.m.

Paper in Chemistry, Pharmacy, Botany or Zoology, from 11.30 a.m. to 1.30 p.m.

Paper in Midwifery, Diseases of Women and Children, from 2.30 to 4.30 p.m.

5th August.

THE ORAL EXAMINATION.

Half the candidates from 9.30 a.m., and half from 2 p.m.

6th August.

THE CLINICAL EXAMINATION.

Medical cases from 9.30 a.m., Surgical cases from 2 p.m.

Examiners to meet in conference at 6 p.m.

7th August.

Practical Pathology, from 9.30 a.m.

Surgical Operations, from 2 p.m.

ALLOTMENT OF MARKS.

In Medicine and Therapeutics.	
Paper	600
Clinical	300
Oral	300
Total	1,200

In Pathology and Bacteriology.	
Paper	350
Oral	250
Practical	300
Total	900

In Surgery and Eye Diseases.	
Paper	600
Clinical	200
Oral	200
Operations	200
Total	1,200

In each of the other three Groups of Subjects.	
Paper	350
Oral	250
Total	600

To qualify, candidates must obtain at least one-third of the total number of marks allotted for each subject, and one half of the aggregate marks for all subjects.

E. STEDMAN, *Major-General.*
Military Secretary.

INDIA OFFICE, WHITEHALL, S.W.
1st May, 1903.

Reviews.

The price of books submitted for review should in every case be stated.

A Manual of Practical Medical Electricity. The Rontgen Rays and Finsen Light. (Ballière, Tindall and Cox). 1902. Third edition. 396 pages, 168 illustrations. Price 7s. 6d. net.

The application of electricity to practical medicine is one of considerable antiquity, and in many respects the treatment by faradism, static electricity, and the constant current holds an undeniable and established position. This is not true yet of Finsen light, ultra-violet rays, high frequency currents, nor even of X-rays. This work has met a distinct want, and is clearly and concisely expressed. In common with most of its kind, it claims too much, and a certain extravagance in the statement of the scope of electrical treatment mars its undeniable merit.

The first 222 pages contain an admirable summary of the varieties of method and electrophysiology. The next thirty pages contain the surgical uses, and here there is much to condemn. The use of an electrical current in any form for such ailments as goitres, aneurysm, strictures, fibroids, dysmenorhœa, malignant growths, and extra uterine fœtation is not recommended by any leading physician or surgeon, and savours of quackery in our present knowledge.

The latter part of the book is devoted to X-rays chiefly and their uses. If the results are all they are claimed to be, the uses of X-rays are enormous; but we are on this point agnostic, in the absence of definite results, though admitting their value in cancer for pain, and in lupus and rodent ulcers as curative agents.

Operative Surgery. By Herbert Allingham. (Ballière, Tindall & Cox.) Pages 367; illustrations, 215. Price 7s. 6d. net.

This work is well-bound, printed on good paper with a large readable print, and is full of intelligible and admirable illustrations. It is more a work for the learners of operative surgery than for the operating surgeon. Ligatures of arteries, and set amputations, with about two exceptions, are rare nowadays. In most cases the particular amputation is devised on surgical principles for the particular case, and arteries are very rarely ligatured as a set operation.

Some of the operations are credited to surgeons whose names are not coupled with them by other writers, *e.g.*, Bennett's operation of varicocele and Allingham's left inguinal colotomy.

Still, allowing for these criticisms and some weak points in detail, there is a great deal of really valuable material in the book, and the memoranda are in general thoroughly sound and practical, bearing in mind, however, that in actual hospital practice very few set book operations are ever performed, the vast majority are modified to suit special cases. As a reference work it is distinctly of value.

Modern Microscopy. By Cross and Cole. (Ballière, Tindall & Cox, 1903.) Pages, 292; illustrations, 72. Price 4s. net.

This contains a good description of the essentials of a good microscope, and the varieties commonly met with.

There is also an excellent part on methods of preparing and mounting entomological specimens, and a very practical article on section cutting and staining.

Practical Pharmacy and Prescribing for Students of Medicine. By James Calvert, B.A., B.Sc., M.D., F.R.C.P. Price 4/6.

This course, supplemented by demonstrations, should prove of considerable assistance to students. The examples suggested for experimental treatment are numerous, and bring before him a large variety of drugs and apparatus, and the more practical work he does the better acquainted will he be with the properties of the various substances used in medicine and the better able to prescribe.

It is inevitable in a book of this kind, that with every effort errors should creep in, but we are sorry to find that ordinary care has not been exercised in eliminating the many mistakes which are found. Although the author gives the right explanations of the Pharmacopœia processes, yet the whole work strikes one as a compilation and shows throughout a lack of practical insight into the details, and a theoretical ignorance of the chemistry underlying the processes. As examples of this, the following may be mentioned—On page 5. In comparing the suspending power of acacia and tragacanth, one is directed to shake the latter with water. Every student knows that tragacanth can only be mixed with water by first moistening with alcohol.

Page 41. Balsams are defined as liquid oleo-resins of such a consistence as to form convenient dressings fo wounds. This is not very descriptive as some are liquid, others solid and brittle.

Under the directions for preparing quinine, it is directed to distil off the chloroform. It is more easily done by means of a separating funnel.

Page 61. We are directed to rub down insoluble powders in a mortar before dispensing, and magnesium carbonate is instanced. This is unfortunate as this substance is just one of the few which do not require such treatment.

Page 72. The author seems to have been entirely at sea with iodides, and to have had the impression that any acid will liberate iodine from them, whereas only those which act as reducing or oxidising agents will do so, such as nitric or nitro-hydrochloric which contains free chlorine.

The latter substance certainly liberates iodine, but it is wrong to give as an example of this the perchloride of iron solution (page 72) as this contains no free chlorine.

Mistakes of the same nature occur on page 78, where sulphuric acid is wrongly said to be incompatible with potassium iodide.

Page 87. Where potassium iodide and caffeine citrate are contained in a mixture.

Page 90. Where free acid is again said to liberate iodine.

On page 79, iodide of morphine(?) is said to be thrown down from a mixture containing strychnine and biniodide of mercury and potassium. As a matter of fact the precipitate would be a double compound. On page 85, one is told not to prescribe bismuth and ammonium citrate with alkalies, but it is only necessary to mention mist. bism. et ammon. citr., G.H.P., as comment to this.

Page 92. Magnesium sulphate is said to be not incompatible with bicarbonates. It is, but not seriously, the only harm which may result is the bursting of the bottle by the carbon dioxide given off.

It will be seen from the above and other instances which might be quoted, that the author has made more difficulties for the prescriber than actually occur.

Manual of Practical Anatomy. Cunningham, Professor of Anatomy at the University of Edinburgh. Upper and Lower Limbs, Abdomen; 605 pages, 203 engravings.

Another edition of this excellent work has been issued, and in it Professor Cunningham has brought up to date descriptions of abdominal viscera. The sigmoid flexure has disappeared, its place been taken by the iliac colon and the pelvic colon which includes part of the rectum.

For the student of medical anatomy, it is the best book we are acquainted with, and the descriptions are as good as formerly and most of the illustrations are better. The coloured engravings of the attachments of muscles will be found of great service, especially for examinations where the exact origin of insertion of the muscles and tendons round the great trochanter has been so long a favourite question.

The work is well conceived, clear and simple in language, and shews great restraint in its scope: digressions and extraneous matter have been rigidly excluded.

Papers by Guy's Men.

A Contribution to the Chemistry of Proteids. Part II. The Constitution of Tryptophane and the Action of Bacteria upon it. By F. Gowland Hopkins, D.Sc., M.B., and Sydney W. Cole.—*Journal of Physiology*, June 15th.

The Chemistry of Alcohol in its Relation to the Body. By F. Gowland Hopkins, D.Sc., M.B.—*Medical Temperance Review* for June.

On the Operative Treatment of Fractures. By W. Arbuthnot Lane, M.S.—*Clinical Journal*, July 1st, 8th and 15th.

The Rôle of Alcohol in Diseases of the Skin. By Dr. Norman Meachen.—*Medical Temperance Review* for June.

Appointments.

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants in Medical Wards.—Messrs. E. H. B. Milsom (Dr. Taylor); G. A. Ticehurst (Dr. Hale White); C. D. Pye-Smith (Dr. Pitt); A. M. Webber (Sir Cooper Perry).

Ophthalmic Dressers.—Messrs. D. R. Pike, H. D. Smart (Mr. Higgens, August 1st); C. H. Reinhold, M. G. Louisson (Mr. Brailey, August 1st); F. H. Wallace (Mr. Brailey, September 16th).

Surgeons' Dressers.—Messrs. J H. Clatworthy, R. Edridge, J. E. Spiller, S. M. Wells, F. Alcock, H. M. Clarke (Mr. Lucas); G. Russell, A. M. Roome, J. Cook, P. F. Minett, L. Myer, A. S. Littlejohns (Mr. Golding-Bird); A. F. Hertz, R. Felton, A. Leeming, E. C. Hughes, C. M. Stevenson, E. W. Sheaf (Mr. Jacobson); W. M. Mollison, J. O. Musson, A. R. Beaumont, W. Reeve, H. D. Wyatt, L. J. J. Orpen (Mr. Symonds).

Externs.—B. Moiser, G. H. Rees, J. M. Pollard, W. N. May, E. C. Myott, R. P. Rowlands (August); C. G. S. Dismorr, F. W. Morton Palmer, R. D. Bridger, G. H. Cheyney, D. Isaacs, E. W. Routley (September); M. Maher, A. V. Maybury, R. Franklin, C. P. Harvey, J. M. Barrionuevo, A. M. Benett (October).

NAVAL AND MILITARY.

Staff-Surgeon E. P. MOURILYAN, M.B., R.N., is appointed to the *President* for temporary service at the Admiralty.

Lieutenant F. H. HARDY, R.A.M.C., is promoted to be Captain.

Obiter Scripta.

WE have received from a correspondent a parcel containing fragments of old medical journals, letters, notes of lectures, etc. The papers are quite yellow with age, and evidently date back to some remote period; the names of the authors, probably with the view of completely obscuring their identity, have been carefully inked over.

The following fragment is an abstract from a lecture on "Physical Signs in Advanced Pthisis," delivered at the Royal College of Physicians by ——, M.D., F.R.C.P.

". . . And, speaking of œgophany, it may be as well for me to say a few words on the etymological definition of some of our medical terms. The sign derives its name, as you all know, from two Greek words, and is thus called from its imagined likeness to the bleating of a goat. In the course of a clinical demonstration to my class the other afternoon, I had occasion to touch upon this subject, and I was astonished to find on individually questioning them on the value of this sign, that not a single student had ever heard a goat

bleat, nor did anyone appear to know why, when or how a goat blet—blot—bleated (which *is* correct?)

"And I must confess that on careful consideration of the point, I could myself remember no occasion on which a goat had bleated in my hearing. I was able, therefore, to press home a very important point with regard to this subject, and that is to regard with a certain amount of distrust, the value which is usually regarded as belonging on the grounds of derivation to many of the conventional terms of medicine.

"I am not at all sure even now that a goat ever does bleat, and if it does, I have not the smallest doubt that it has a much better reason for doing so, than we have for traducing the quality of his vocal apparatus. I shall, however, have more to say on this subject in my next lecture."

The following fragment was written in shorthand, and was almost illegible. With assistance, however, we have managed to transcribe it, and it appears to consist of notes hurriedly made at Medical Out-patients:—

". . . . Well, of course, as you see, she's got a whacking great heart, reaching 9½ inches to the right of the sternum, with the apex beat 6 inches outside the nipple line. What can you do for people like this? Of course as a matter of fact you know, she ought to be in bed with her feet up against the ceiling, but what is the good of my telling her to go to bed, when she's got to keep on making straw hats at 3d. an hour? The condition of these people too, is always aggravated by their taking unsuitable food, especially at night; I dare-say this patient takes supper regularly, probably stewed eels or that kind of thing. What? eh! you do? I thought as much. Now look here, you must never take any more supper as long as you live; you never ought to eat anything at all after breakfast time.

"What? No, it's not a bit of good giving digitalis or any of those wheezes in a case of this kind. Don't you see that if the physiological balance is upset, if you find that the blood pressure is——well, as I said before ——in a case like this you must——in other words if you have your peripheral resistance raised to its maximum, what can you expect when—— What? Is that all of 'em? Well look here you fellows, I don't know what you're going to do, but I'm off."

The next fragment speaks for itself:—

Clinical lecture on "Suprapubic Neuritis," by ———, M.D., F.R.C.P.

". . . . And now if you will only think for a moment, it is perfectly easy to settle the question of the differential diagnosis in appendicitis. You are all familiar with the classical symptoms in the latter complaint, the pyrexia, the vomiting, the pain at McBurney's point, etc. On the other hand, if you have a doubtful case of pyrexia, which makes you think it possible that suprapubic neuritis may be present, and if the pain is localised over an area reaching from a point three-eighths of an inch internal to McBurney, to a point one sixteenth of an inch to the south-west, and if this pain is associated with a leonine expression, a rolling eye (particularly the left one), an ataxic gait, absolute coma, and an inability to correctly pronounce the word 'syllable,' then it absolutely clenches the diagnosis in favour of suprapubic neuritis.

"As to treatment, well it is not possible to do much; a few years ago we used to give them 5 grains of valerianate of zinc every ten minutes; now we give arsenic, and we find that it does just as much good as anything else.

"The prognosis is, of course, *very* bad, only 4 per cent. usually recover, and if *they* happen to be over 80 they die too. The friends will often ask you if nothing can be done; well all that I can tell you is this, that if the patient becomes so collapsed that it is obvious the end is only a question of a few hours, the surgeon may be called in, but from what I have told you, you will be prepared to hear that he can do but little good. . . . ."

The following is a portion of a letter addressed to a Revd. Mr.———:—

". . . I am obliged by your cheque for 375 guineas, balance of fees, receipt of which I duly enclose. The Dean is at present away for a few days' change, but on his return I will not fail to ask him about the extra charge of 75 guineas, which you complain of; I rather think however that it has something to do with broken test tubes, but I feel sure that he will be able to enlighten you. In reply to your second question, we can give a very good account of your son: he is not addicted to billiards, and has never been seen up West after three o'clock in the afternoon, and indeed except for the occasional indulgence of a cigarette, we think you may consider him comparatively speaking free from vice.

"I am, Sir,

"Yours faithfully,

"———."

The following was another letter, but written in such a terrible hand as to be almost illegible:—

". . . . I am awful afraid I shall not able to get round to Out-patients' next week; I have promised to turn up at the War Office garden party and the following week I am going down to Ascot with Lord Bladafase.

"You might ask Doodle to take the outers for me both those days; and as to the operations, I will be round about 6 o'clock next Wednesday to see to the old lady in No. 20 with the Spina Bifida; I think I shall try the high operation this time, *i.e.*, resect the whole of the dorsal vertebræ and stitch the cauda equina to the back of the neck. You can easily yourself manage those 3 cases of ingrowing toe nails, and you could let the Dressers see to those 4 hydroceles. I was glad to hear you found no difficulty with the sebaceous cyst; I have just had a letter from her saying she is now on her legs again thanks to you. Good man!

"Bye, bye, Yours,

"———."

Novelties.

JEYES' SPECIAL FLUID AND JEYES' DISINFECTANT.

In appearance of a dark color, miscible with water to form a milky, soapy emulsion which gives a slightly alkaline reaction and has a not unpleasant odour.

The makers correctly state the former fluid contains no carbolic acid nor any of its homologues, but a new substance discovered in coal tar which is said to be ten times stronger as a germicide than carbolic acid, and eight times less toxic on the higher forms of life. These latter statements, apparently self-contradictory, appear to have been borne out by the experience of Dr. Houston (*Practitioner*, Sept., 1902). The fluid has been tested by Dr. Klein, who found that 1 in 400 solution was a complete disinfectant for staphylococcus pyogenes in five minutes' exposure, also that in 24 hours tubercle bacilli, dried on wood, became completely disinfected.

It is a fluid that may be used for a disinfectant or as an antiseptic.

Sport.

Cricket.

GUY'S 2nd XI. v. MERCHANT TAYLORS A.

Played at Bellingham on June 6th, resulting in an easy win for our team. Scores:—

GUY'S 2ND.

M. Macpherson, lbw, b Strachan	39
F. A. Husbands, b Hare	17
A. Leeming, lbw, b Hare	3
E. L. Norton, not out	52
S. M. Wells, c Jamieson, b Strachan	14
A. M. Tolhurst, c Maroni, b Elderton	62
H. G. Gibson, b Elderton	8
S. A. Piper, lbw, b Strachan	6
G. Russell, b Strachan	1
Extras	12
Total (8 wickets)	214

D. G. Wearing and G. N. Bartlett did not bat.

MERCHANT TAYLORS A.

J. P. Jamieson, b Wearing	1
R. Wimbush, b Russell	6
H. B. MacMinn, c Macpherson, b Russell	4
T. H. Elderton, b Russell	0
C. B. Ewart, b Russell	0
S. T. Williams, c Wells b Russell	9
D. Maroni, b Bartlett	12
G. C. Hutchinson, c & b Wearing	1
G. Saunder, c & b Bartlett	21
J. D. Strachan, b Husbands	0
M. E. Hare, not out	0
Extras	9
Total	63

GUY'S 2ND v. BLACKHEATH "A."

Played at the Rectory Field on June 20th. The match was drawn in our favour. Scores:—

BLACKHEATH "A."

R. W. Foster, c Bartlett, b Russell	1
F. Exhaun, c Leeming, b Bartlett	47
A. P. Park-Smith, b Piper	0
H. Poore, lbw, b Tolhurst	43
H. Yeoman, c Russell, b Bartlett	15
C. E. S. Mason, b Bartlett	19
R. A. Robson, b Piper	7
T. Chamberlain, not out	6
H. Rogers, b Piper	0
Capt. Wilson, c Allison, b Bartlett	6
Extras	14
*Total (9 wickets)	158

* Innings declared closed.

GUY'S 2ND.

F. Morres, b C. E. S. Mason	54
J. S. Bookless, run out	3
F. Husbands, not out	36
A. Leeming, not out	6
Extras	5
Total (2 wickets)	104

A. M. Tolhurst, M. Macpherson, A. G. Allison, S. A. Piper, G. Russell, H. G. Gibson, G. N. Bartlett, did not bat.

ST. THOMAS'S 2nd v. GUY'S 2nd.

REPLAYED CUP-TIE.

Played at Honor Oak on Tuesday, June 30th. After making 234 for 9, we dismissed our opponents for 54. For us, Tolhurst played a good innings of 72 not out; he was well backed up by Bookless, Husbands and Gibson. Scores:—

GUY'S 2ND.

J. Bookless, b Devass	31
E. L. Norton, b Thompson	11
F. H. Husbands, c Sington, b Devass	35
M. Macpherson, b Wooten	5
A. M. Tolhurst, not out	72
S. M. Wells, b Devass	8
G. Greening, c Bletsoe b Wooten	12
G. N. Bartlett, c Thompson	8
H. G. Gibson, c Wooten, b Treves	31
S. A. Piper, c Bingham, b Treves	8
G. Russell, not out	2
Extras	11
Total (for 9 wickets)	234

ST. THOMAS'S 2ND.

R. Thompson, retired	23
H. Devass, c Bookless, b Bartlett	0
R. Bingham, c Piper	6
J. Wooton, b Bartlett	0
F. Dulghish, b Bartlett	2
R. Mould, st. Gibson, b Russell	8
J. Bletsoe, c Husbands, b Bartlett	4
W. Morton-Jack, c Piper, b Bartlett	1
H. Sington, b Bartlett	1
J. Treves, b Russell	3
C. Bennett, not out	0
Extras	6
Total	54

GUY'S 2nd XI. v ST. THOMAS'S 2nd XI.

SEMI-FINAL CUP-TIE.—JUNIOR CUP.

This match was played at Chiswick Park last Friday. After compiling 247 for 3 wickets, we were unable to get our opponents out in time, and the game was left drawn in our favour. Bookless played an excellent innings of 101 not out, and was well backed up by the other batsmen. Scores:—

GUY'S 2ND.

J. S. Bookless, not out	101
E. L. Norton, c Wooten, b Mould	28
F. A. Husbands, b Devass	25
M. Macpherson, c Sington, b Wooten	42
A. M. Tolhurst, not out	26
Extras	25
Total (for 3 wickets)	247

Wells, G. Greening, Bartlett, Gibson, Piper, Russell, did not bat.

ST. THOMAS'S 2ND.

Thompson, c Tolhurst, b Bartlett	35
Wooten, c Wells, b Piper	10
Devass, c & b Piper	18
Bingham, b Bookless	15
Pawson Smith, c Gibson, b Bookless	0
Mould, not out	14
Morton-Jack b Russell	1
Treves, c Wells, b Bartlett	6
Sington, c Tolhurst, b Bartlett	9
Extras	15
Total (for 8 wickets)	123

Bletsoe and French did not bat.

GUY'S 3rd XI. v. CAMBERWELL HOUSE.

This match, played at Camberwell, Saturday, June 27th, ended in a win for the hospital, by 82 to 68 Bartlett bowled well, taking 7 wickets for 21 runs.

GUY'S.

G. Greening, b Milton	8
A. Leeming, b Milton	8
M. Tolhurst, c Moore, b Ross	11
H. H. Moyle, b Ross	2
H. G. Gibson, b Milton	2
G. N. Bartlett, b Ross	0
T. R. Harvey, b Milton	0
A. D. Vernon-Taylor, c Ross, b Turner	2
D. G. Wearing, b Ross	0
J. F. Young, b Ross	23
W. H. S. Burney, not out	6
Extras	20
Total	82

CAMBERWELL HOUSE.

Higgs, c Wearing, b Bartlett	28
Mitchell, b Bartlett	6
Raymond, c Greening, b Young	7
Ross, b Bartlett	0
Rose, c Moyle, b Bartlett	3
Sergeant, run out	4
Parsons, b Moyle	2
Stringer, b Bartlett	0
Milton, not out	9
Moore, c and b Bartlett	0
Turner, b Bartlett	0
Extras	9
Total	68

GUY'S 3RD v. HOS.-SCHO.

This match was played at Honor Oak Park on Saturday, July 4th, and ended in an easy victory for the Hospital. The Hos.-Scho. batted first and made 113, Arnold played a good innings for 55. Guy's knocked off the runs for five wickets, and eventually made 204. Harvey, Jones, Rice and Moyle all batted well. Scores:—

HOS.-SCHO.

Arnold, b Young	55
Holcroft, c Rice, b Jones	8
Hussey, b Young	12
Bailey, b Rice	0
Browsden, c Carter, b Young	11
Kopsey, run out	1
Cooper, b Rice	9
King, b Rice	4
Pelling, b Rice	0
Pullen, c Harvey, b Moyle	5
Bush, not out	0
Extras	8
Total	113

GUY'S.

R. Willan, Sen., c Arnold, b Bailey	14
A. D. Vernon Taylor, b Hussey	4
H. H. Carter, b Bailey	0
H. H. Moyle, b Hussey	31
T. R. Harvey, b Cooper	65
J. F. Young, b Hussey	1
G. E. Rice, run out	32
A. G. Jones, b Kopsey	36
P. F. McEvedy, not out	10
G. Nunn, b Kopsey	0
H. N. Eccles, b Hussey	1
Extras	10
Total	204

Guy's Hospital Lawn Tennis Club.

On Saturday, June 6th, we lost to Surbiton "A" by 4 events to 5.

Lucas and Palmer beat Bell and Wyatt, 7–5, 3–6, 6–3; beat Armstrong and Featherstonehaugh, 6–2, 5–7, 6–4; beat H. S. and R. Hopkins, 6–2, 5–7, 6–4. Zorab and Earle lost to Armstrong and Featherstonehaugh, 6–2, 4–6, 2–6; beat Bell and Wyatt, 6–4, 9–7; lost to H. S. and R. Hopkins, 4–6, 5–7. Cutler and A. Palmer, lost to H. S. and R. Hopkins, 2–6, 1–6; lost to Armstrong and Featherstonehaugh, 3–6, 3–6; lost to Bell and Wyatt, 3–6, 4–6.

Having drawn a bye in the first round of the Senior Inter-Hospital Cup, we played London on Thursday June 25th, at Chiswick, and were beaten by 10 matches to 3.

In the singles—Lucas beat Mott, 6–4, 6–4; F. Palmer beat Bousefield, 6–3, 3–6, 6–3; Zorab lost to Smith, 5–7, 6–2, 3–6; Earle lost to Fisher, 3–6, 3–6; A. Palmer, lost to Iles, 2–6, 2–6; Cameron lost to Jones, 1–6, 2–6.

In the doubles.—Lucas and Palmer lost to Mott and Iles, 3–6, 1–6; lost to Fisher and Smith, 4–6, 2–6; beat Bousefield and Jones, 4–6, 6–3, 6–2. Zorab and Earle lost to Fisher and Smith, 2–6, 2–6; lost to Mott and Iles, 3–6, 4–6. A. Palmer and Cameron lost to Bousefield and Jones, 2–6, 2–6; lost to Fisher and Smith, 1–6, 1–6.

On Saturday, June 27th, we beat the Brixton Wanderers by 5 events to 4, at East Dulwich.

Lucas and F. Palmer beat Swan and Andrews; beat Palmer and Tucker; beat Smith and Jones. Zorab and Earle lost to Swan and Andrews; beat Palmer and Tucker; beat Smith and Jones. Cameron and Turner lost to Swan and Andrewes; lost to Palmer and Tucker; lost to Smith and Jones.

Guy's Hospital Rifle Association.

ARMITAGE CUP.

Fourth Shoot, Runnemede, Wednesday, June 24th, 1903.

	GUY'S.
R. E. French	92
J. S. Cooper	91
R. Felton	88
G. A. Ticehurst	84
F. B. Lowe	70
L. M. Ransford	68
TOTAL	493
St. Bart.'s	510
St. Thomas's	485

The three best scores aggregate respectively as follows:—

Guy's.	St. Bart.'s.	St. Thomas's,
482 ...	476 ...	461
487 ...	471 ...	489
493 ...	510 ...	485
1462	1457	1435

We have thus obtained one more Challenge Cup by the narrow margin of five points.

Papers by Guy's Men.

The Influence of Ablation of the Liver on the Sugar Contents of the Blood. By F. W. Pavy, M.D., F.R.S., and R. L. Siau.—*Journal of Physiology*, June 15th.

On the Mechanism of Phloridzin Glycosuria. By F. W. Pavy, M.D., LL.D., F.R.S., T. G. Brodie, M.D., and R. L. Siau.—*Ibid*, June 16th.

Lectures on Some Affections of the Hip. By A. H. Tubby, M.S., F.R.C.S. Lecture II. Coxa Vara.—*Clinical Journal*, June 24th.

Lecture III. Congenital Dislocation of the Hip.—*Ibid.*, July 1st.

Some Remarks on the Finsen Light Treatment of Lupus. By W. Kenneth Wills, M.A., M.B., B.C. Cantab., M.R.C.S. — *The Bristol Medico-Chirurgical Review* for June.

The Uses of Sodium Salicylate in the Treatment of Malarial Fever. By A. D. E. Kennard, L.R.C.P. Lond., M.R.C.S.—*The Lancet*, 11th July.

Protruding Auricles Treated by Operation. By T. G. Ouston, F.R.C.S. (Illustrated). — *British Medical Journal*, July 4th.

Births.

PANTIN.—On June 28th, at Douglas, Isle of Man, the wife of C. S. Pantin, M.D. Lond., F.R.C.S., of a daughter.

STEWART.—On July 9th, at Ware, Herts, the wife of Walter G. Stewart, M.B., B.S. Lond., L.R.C.P., M.R.C.S, of a son.

Marriages.

CANN—HICK.—On July 8th, at Ashley Church, Staffs., Francis John Hughtrede Cann, M.B. Lond., of Dawlish, Devon, to Norah Frances Hick, daughter of B. Hick, of Bramley Cross, Lancs.

GARRARD—WINCKWORTH.—On July 7th, at Shefford Church, by the Rev. G. M. Osborne, M.A., rector, assisted by the Rev. H. N. Dymond, M.A., and the Rev. William Williams, the Rev. William Austin Garrard, M.A., of Kempston, Beds., third son of Thomas E. Garrard, of Beckenham, Kent, to Muriel Eveline, daughter of C. E. Winckworth, Esq., Surgeon, Shefford, Beds.

Death.

WOODMAN. — On June 28th, at his residence, 2, Chichester Place, Southernhay, Exeter, John Woodman, M.D., F.R.C.S., in his 67th year.

ED.—J. M. B.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review should be forwarded, accompanied by the name of the sender, to the Editor, Guy's Hospital Gazette, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the Gazette *bound should leave them with the Librarian.*

The annual Subscription to the Gazette *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. Wells, Secretary's Office, Guy's Hospital.

The charge for binding in blue, with the Arms of the Hospital in gold, will be One Shilling and Sixpence.

Guy's Hospital Gazette.

AUGUST 1, 1903.

Some Problems from "Clinical."

CLINICAL LECTURE BY Dr. L. E. SHAW.

June 17th, 1903.

Gentlemen,—As this is the last clinical lecture of this series which I shall have the honour of delivering to you this session, I thought that instead of bringing a single case or subject before you to discuss during the weary fifty minutes, I would mention a few obscure cases which have presented to us unanswered problems in diagnosis, or have served us to base discussions upon with regard to the wrong interpretation of physical signs or the propriety of treatment not crowned with success; a sort of mince of the hashes we have made in Clinical during the last few weeks.

Ocular Paralysis.

The first problem I bring to you in the flesh, this small boy. His is a case of somewhat obscure oculo-motor paralysis. I am always, when on the threshold of investigating a case of oculo-motor paralysis, haunted by an imperfect memory of a very elegant diagram and table devised as a *memoria technica* to enable one at a moment's notice to find out exactly what muscle is paralysed by a consideration of the character of the double vision. I remember learning such a *memoria technica* years ago; I did not understand it, but I knew it word for word. I learned it from a certain familiar journal which is published fortnightly, and what was my horror when the next fortnight's issue came out to find that there was a serious misprint, which made all that I had learned totally useless. I promptly learned the new one. Since then, however, I regret to say I remember neither. But one of the great charms of this case before us is that the paralysis is so complete that the boy has not got any double vision; therefore we are not in the least worried by projections and figures, and that sort of thing. I think I can easily demonstrate to you as you are sitting there the main features of this boy's paralysis. You will see that he has drooping of both his eyelids—double ptosis; if he wants to look at you he has to throw his head back. As a consequence of his ptosis he has constant deep transverse wrinkles on his forehead, the result of over-action of his frontalis muscle; this is due to an attempt on the part of the frontalis muscle to make up for the ptosis from which he is suffering. Seven weeks ago the boy was perfectly healthy, except that he probably had then, what he has now, an enlarged thyroid. We do not know what this is due to, but we think it is some form of simple goître, and that he perhaps has a cretinoid tendency. He is eleven years of age, and six weeks ago he went for what was for him a long walk with his father, a distance of twenty miles. Next morning his mother noticed that he was unable to raise one eyelid, which she naturally attributed to sleepiness. After a little while she found he could not raise the other eyelid, and then she called in a doctor, Dr. Featherstone, of Aldershot, an old Guy's man, who sent the case up here. Dr. Featherstone immediately recognised that there was something more than this double ptosis; he found the condition of the eyes which is still present. I may therefore go on

to a further description of the case as you see it, because his symptoms now are practically those found by Dr. Featherstone six weeks ago. You can see that both eyeballs are directed outwards the left further out than the right—there is a double divergent strabismus. If you will watch the movements which he can make I think you will see that they are very few. He does not move his eyes upwards at all. As he follows my finger you will see that in his right eye there is very slight movement downwards and inwards, and in his left eye there is no movement downwards at all. The boy will be "at home" in Clinical every afternoon this week, so that any who may desire to test these movements for themselves may do so.

Now, if I try to make him look to the right you perceive that this left eye does not come at all towards the middle line. Although the right eye comes out to the outer canthus, a similar effect is produced when he tries to look to the left. In either case when his eyeball gets to the outer canthus there is a slight nystagmus. The pupil of the more paralysed eye is a little larger than that of its fellow. There are some other interesting features, which you will be able to make out for yourselves, but which it would be tedious to go over now. It is not difficult for you to realise that this boy has, essentially, a paralysis of his third nerve on both sides, and of his fourth nerve on the left side. There is some difference of opinion as to whether he has anything which could be called paresis of his sixth nerves; but he certainly has not got paralysis of them, for either external rectus will take his eye into the outer canthus. I bring this case before you because we have some difficulty in determining both the situation of the lesion and its nature. The actual form of the paralysis is fairly simple, but the problem is, what is the nature of the lesion and where is it situated? I should like to say at once that I have received considerable assistance by discussing this case with several of my colleagues working in the Ophthalmic department, and it is rather because they lead me to believe that the case is not absolutely straightforward that I bring it before you; my own incapacity to diagnose the situation of the lesion in a case of oculo-motor paralysis would not justify me in thinking that the obscurity necessarily lay in the case. You all know that if you are going to try to make a diagnosis of a nervous lesion there are two points to which you must pay attention. You must first diagnose the situation of the lesion, and then diagnose its nature. It is chiefly, perhaps, in nervous diseases that the necessity for the preliminary accurate diagnosis of the situation of the lesion is so prominently before you. With regard to lesions of the liver, or the heart, or the stomach, the fact that the disease is situated in a certain organ is not, as a rule, so difficult to determine as the nature of the lesion.

Most patients, indeed, consider themselves competent to decide whether it is a specialist for the heart, liver or stomach whose care they require. But in diseases of the nervous system the diagnosis of the seat of the lesion is often the main difficulty.

With regard to the situation of a lesion producing paralysis of muscles of the limbs, the first essential is to determine whether the lesion is what we call a supra-nuclear or an infra-nuclear lesion; that is to say, whether it is a lesion of the upper neuron or of the lower neuron. In cases of ocular paralysis, such as we have before us to-day, there is no such difficulty; you may at once dismiss from your mind the possibility of this being a lesion of the upper neuron. We will put it in this way: lesions of the upper neuron paralyse movements rather than muscles; and therefore the ocular paralyses which are dependent upon lesions of the upper neuron are not paralyses of certain particular muscles of the eyeball, but they are paralyses of certain coordinate movements of the eyeball.

When a man has a lesion in his internal capsule or some other part of the upper neuron which produces some oculo-motor paralysis, there ensues an inability to perform associated movements of the two eyes; the patient is unable to turn both eyes to one side or to the other side, but he is never in the position of this boy, of having one eye turned one way, and the other eye turned the other. So we are confident that the paralysis is not due to a lesion of the upper neuron in this case. Then it resolves

itself into a question of whether the lesion is in the nucleus or in some part of the nerve between the nucleus and the muscle. I have been able to find, in my conferences with various authorities about this case, some who hold that the lesion is in the nerve, and others who hold that it is in the nucleus. Those who hold it is in the nerve offer us two choices of a diagnosis as to the exact cause. And again, those who hold that it is the nuclei which are involved believe that there are two possible lesions which might be responsible. The point is, have we got in this case some lesion involving both third nuclei and one fourth nucleus, or have we got a lesion which is pressing upon both third nerves and one fourth nerve? If it were a lesion pressing upon the nerves I think that we may at once say that it would be likely that any gross material sufficiently large to cause paralysis by pressing upon these nerves at the base of the brain would almost certainly produce other symptoms of intracranial pressure. Notwithstanding this, I must confess that was the explanation of the case that first occurred to me; I thought probably the boy had a tumour or some collection of material—lymph or blood—at the base of his brain, which was involving the nerves. But the most careful scrutiny of my clinical assistant, Mr. Spriggs, has only enabled us to say that this patient, in the seven weeks since the onset of symptoms, has once been a little sick, that he felt a little giddy one morning, and that he had headache the day after he came into the hospital. We were not sure that the ache was not really in his heart, as he was somewhat sad at the separation from his mother. Everyone who has examined the boy's eyes is agreed that there is no optic neuritis.

We feel that we ought to have more definite evidence than this and of some of the classical signs of cerebral tumour, if there be one large enough to so completely involve the nerves. And the same may be said with regard to the probability of the compression being caused by some effusion of blood or lymph at the base of his brain. If he had such an effusion as the result of over-exertion in his long walk, it would have been likely to have produced other symptoms besides those due to the localised lesion of cranial nerves. And that leads us to incline to the view that we have to deal with a lesion in the nuclei of the third and fourth nerves. You know these nuclei in the floor of the fourth ventricle, situated close together, almost in contact with each other. In considering possible lesions of the nuclei that may produce such a condition. I think we may dismiss from our minds those not very rare cases in adults, where there are nuclear lesions associated undoubtedly with vascular changes—a form of "apoplexy." Such patients are the subjects of small hæmorrhages into the floor of the fourth ventricle, which compress the nuclei, and also do many other things as well. The ocular paralyses are associated with other more serious symptoms. I confess that the suggestion made to me by one of my colleagues which most commends itself to me, is that this acute condition of paralysis is due to an affection of the nuclei of the boy's oculo-motor nerves, analogous to the acute affection of the large cells in the anterior grey horn with which you are so familiar in cases of so-called anterior poliomyelitis, or acute infantile paralysis. If we had heard, for instance, that this boy, after his twenty-mile walk, had on the next day an attack of feverishness and loss of power in arm or leg, or in both legs, and we had found that he had simply a limited paralysis of his muscles, without any sensory phenomena at all, we should undoubtedly have concluded that it was a case of anterior poliomyelitis, some condition of an inflammatory or hæmorrhagic nature in the large cells of the grey horns, which had led to the complete paralysis of certain groups of muscles. I am told that if we accept this view we must call the case one of "Acute polioencephalitis superior Werwicke," but I note that Gowers says that this is an inaccurate term which ought not to come into use, and I am sure you will heartily agree with him that it ought not to. Let us call it infantile paralysis affecting ocular muscles. I should not like to say positively that this will remain the final diagnosis, but, taking the position of umpire, I should say that is the most likely one which has been submitted to me, and must serve our purpose while we wait with some anxiety to see whether further developments take place to throw additional light upon our problem No. 1.

Cerebral Abscess or Tumour.

There is another case which gave us some difficulty. Some of you, I hope, are in a better position with regard to this problem No. 2 than I am. I did not see its answer; I only saw the question. The patient died on Monday, and I was unable to be present at the autopsy. It was an interesting demonstration, and I hope many of you were present in the post-mortem room. It was a case in which the very old problem presented itself, as to the diagnosis between a cerebral abscess and a cerebral tumour. This is a difficulty which will be pretty frequently before you.

As we were by no means confident of the diagnosis until the *post-mortem* examination, I thought it might be well for you if I tried to point out some of the difficulties in such cases. You know that there are five great Hippocratic signs common to cerebral abscess and cerebral tumour, some or all of which you are likely to find in any case of either of these diseases. You are, of course, not certain to find all of them, but you are likely to find some of them in combination: these signs are headache, vomiting, vertigo, optic neuritis, and fits. They are called Hippocratic because they were taught by Hippocrates, only, of course, Hippocrates did not say anything about optic neuritis, he spoke of its resulting symptom—blindness. All those signs, you will notice, are due to increased intracranial pressure. Seeing the great difference between the slowly-growing solid tumour and the more rapid growth of the collection of pus, you might have thought there would have been great differences in the indications of intracranial pressure; but you must remember that the rapidity of the development of the signs of intracranial pressure in a case of abscess is counterbalanced by the greater extent of the development of the signs of intracranial pressure in the case of a tumour. In either case the explanation of the serious pressure effects is to be found, of course, in the fact that the morbid product is developing within a cavity incapable of expansion—the cranium.

Little help is afforded by considering the extent of these five signs in deciding whether you are dealing with a case of abscess or of tumour. One of these symptoms, however, is strikingly more common in one condition than in the other, and that is optic neuritis. A much smaller proportion of cases of cerebral tumour run their course without optic neuritis than of cerebral abscess; and that is only another way of saying that optic neuritis is, after all, a secondary result of the intracranial pressure, and is only produced when the intracranial pressure has been present to a considerable extent for a long time. Nor will the presence or absence of what at first sight you would expect to find in cerebral abscess but not in tumour generally be of much assistance to you, viz., the ordinary signs of suppuration. If you have deferred, as many of you do, the consideration of nervous diseases till you have read through the rest of your text-book in medicine, you will when you come to them know all about abscesses in other parts, and you will be surprised to find that it is a common observation in cerebral abscess to find pyrexia and rigors absent during the whole of the case. If it were not for that I think you would at once see that the differential diagnosis between abscess and tumour would not be very difficult. But rigors and pyrexia are by no means uncommonly absent, even when there is a most acute abscess in the brain. Indeed, when they are present in a case which presents other signs of cerebral tumour the possibility of meningitis as a diagnosis immediately comes in. But I must not complicate the case by introducing meningitis to you this afternoon. I have told you that there are these five common symptoms in both diseases and that the characteristic signs of suppuration, namely, fever and rigors, are frequently absent, and I must point out to you that, that being so, the diagnosis generally depends upon there being in a case of cerebral abscess almost always evidence of a primary cause for the suppuration, whereas in tumour there is generally no evidence of any other disease in any other part of the body. This fact was impressed upon me very much many years ago when I was making a post-mortem examination as Medical Registrar. As I had passed through the colonnade on my way to the post-mortem room I had noticed the diagnosis posted, "? cerebral abscess, ? cerebral tumour;" and I was

therefore wondering which I was about to find. And as I was preparing to examine the brain a messenger came to say that the physician under whose care the case was, having also passed through the colonnade and seen these two doubtful diagnoses written up, desired it to be known that his diagnosis was cerebral tumour, for he explained there was not in the patient any discoverable cause for cerebral abscess. Just at that moment my knife entered a large collection of pus in the brain. This incident impressed me with the great difficulty of distinguishing sometimes between the two conditions we are discussing. Not only had the physician made a definite diagnosis which was wrong, but he had been more unwise still for he had given the reason for his belief. We then proceeded further, and examined the patient's thorax, and found at the base of one of her lungs a typical bronchiectatic cavity, which was undoubtedly the primary cause of the cerebral abscess. It was not to be wondered at that the physician had been unable to discover the bronchiectatic cavity, for it was a small one and the corpse was one of the fattest on which I have ever had the discomfort of making a *post-mortem* examination. The lesson I learnt and I want you to learn is this. Though the physician was wrong in the individual case, the principle he relied on was the right one. This still remains the best diagnostic factor to which you can cling when you are in difficulties in diagnosing between cerebral tumour and cerebral abscess. If it is abscess there should be some evidence of old otorrhœa, which accounts for a large majority of the cases, or there should be evidence of old ethmoiditis, or indications that the patient has had a fractured base of the skull recently, or syphilis, causing necrosis of cranial bones, or lastly, some evidence that there is a suppurative focus in the thorax, either empyæmia or bronchiectasis, from which pus can be carried into the brain.

I have not yet told you anything about our case. It was a child five years old, who, so far as we could ascertain, had been acutely ill only five days, with headache, vomiting, slight pyrexia, and undoubted evidence of some gross change inside the brain, which was pressing somewhere upon the motor tract. There was also a history, which I now believe to have been a wrong one, of a discharge from the ear. This association of symptoms led us to believe there was a cerebral abscess. I got Mr. Lane to explore in the cerebellar and temporo-sphenoidal regions, on the side indicated by the paralytic symptoms, but he could find no pus. When the patient died, a tuberculous tumour was found in the pons, with a little subjacent meningitis. Looking back upon the case I wonder whether the acute symptoms were due to the meningitis, and the other symptoms of tumour had been present for some time but had been overlooked until the patient came into the ward.

Intussusception.

Lastly, I will refer to two cases which presented several problems for discussion, two cases of intussusceptiom. One of these cases we inflated, and it is living; upon the other we performed laparotomy and it is dead. You must draw no hasty conclusions as to the relative value of these methods of treatment from the results in these two cases. I have lived long enough to have seen a marked change come over the profession with regard to the treatment of intussusception. In my early days as an assistant physician here it was our custom to postpone laparotomy to the last moment, and, as you may imagine, we had very unsuccessful results therefrom. I see now papers in the medical journals which would seem to indicate that it is the absolute duty of every practitioner, the moment he sees any child with an intussusception, to open the abdomen in order to reduce it. It is only the old case of the pendulum swinging first too much on one side and then too much on the other. These two cases which we have had in Clinical have led us to discuss one or two points which, if they could be clearly settled, would enable us to steer a medium course, with greater benefit to our patients. I will put these problems in the form of a series of questions which I will ask and endeavour to answer—

(1.) Is it possible, in the majority of cases of intussusception, to reach a diagnosis early enough to enable inflation to be successful? This question of early diagnosis is the chief difficulty.

If we could recognise certain forms of intussusception early enough, it is almost indisputable that by gentle inflation, or the injection of fluid into the colon without undue pressure, the intussusception could be reduced and the patient's life saved by a simple procedure involving very little risk. But this lack of early recognition is the old trouble which is constantly before us in many things besides intussusception. In cancer of the stomach, acute obstruction, general peritonitis and other lesions, the surgeon says: "If you physicians would only give us these cases early enough we could always cure them." The physician replies: "How can I ask you to operate until I know the patient has got the condition? The early diagnosis of these diseases is extraordinarily difficult."

Again, in intussusception where the early diagnosis is generally much easier, the physician lays the blame on the general practitioner for not sending the case early enough to the hospital. The general practitioner places the blame further back and says: "It is the mother's fault; she will not bring me her child until it is seriously ill." There was one feature common to these two cases which made me pause for a moment. In both these cases the patient had been seen in the front surgery on the day previous to admission into the hospital and been sent home. That made me think that at least here were cases in which a careful consideration of whether the child had got intussusception or not had led to the definite but erroneous conclusion that it had not.

If we are conscious that in all such cases we have carefully considered the possibility of intussusception, we need not in the least upbraid ourselves for not having reached an accurate diagnosis. But whenever a mother brings a child with the complaint that it has been passing blood *per rectum*, or that it has occasional paroxysmal stomach-ache and vomiting, we must at least take care it comes into our mind that it may be a case of intussusception. We must examine the abdomen to see whether there is the definite typical tumour of intussusception, if necessary under an anæsthetic. I am prepared to say that if such care were usually adopted the vast majority of cases of intussusception would be recognised early enough to be cured by inflation without the risk of laparotomy. Unfortunately many such cases in the hurry of practice are regarded as due to some simple gastro-intestinal obstruction and valuable time lost. But there are some cases of intussusception that from their anatomical peculiarities cannot be successfully treated by inflation, however early they are recognised, and that brings me to my second question.

(2.) Is it possible to distinguish those cases which, anatomically, are amenable to treatment by inflation, from those which are not? This question was very much pressed upon my mind because in the patient whom we submitted to laparotomy, after having unsuccessfully tried inflation, we discovered at the operation that there was a form of intussusception which could not under any circumstances have been reduced by inflation; it was ileic. You know that in the majority of cases there is an invagination of the small intestine into the larger, and in such cases by blowing into the large intestine you can force the small intestine out. But here was a case in which we had attempted to do this, although the invagination was confined to the small intestine some distance above the ileo-cæcal valve, and we had thus lost golden hours. Just as in all cases presenting suspicious symptoms we ought to think of intussusception, so in every case in which we know there is intussusception, and are about to attempt to reduce it by inflation, we should previously consider whether it is possibly one of those cases where the intussusception is entirely in the small intestine.

Looking back upon this case, I think I observed an unusual position of the tumour, which ought to have led me to think of this if it had been in my mind; but it was not. The ileic variety is very rare.

(3.) The third question I want to ask is this: Is it possible to tell, after inflation, whether the procedure has been successful? This is a most important question, because if you knew you had not successfully reduced the invagination by inflation you would not wait a moment before having laparotomy performed. But there is a child under an anæsthetic with a flaccid abdomen, in which you feel an obvious

lump. And you begin to force air or allow fluid to run up into the colon by hydrostatic pressure, and immediately the abdomen gets larger, and you joyously feel the lump getting less and less distinct, and if you are a novice, when you feel it no more, you conclude that the intussusception has been reduced. Very likely it has not, but you have so distended the other coils of intestine that the lump, much reduced in size, has become impalpable, although it is still present. The more carefully you manipulate the patient's abdomen after you have inflated it, the more likely you are to draw a right conclusion; but even when you are most confident of success you must still watch your patient carefully, and be prepared at the first sign of any recurrence of symptoms, to repeat your operation, or to call in the surgeon to do a laparotomy.

There is another problem with regard to this subject which interested me. In the case of the child with the ileic intussusception, after an ineffectual attempt at inflation, laparotomy was ultimately performed, and when the abdomen was opened we found a very tight intussusception which was quite irreducible. No time was wasted; the surgeon immediately recognised that it was irreducible, and in the most skilful and rapid manner cut out the intussuscepted portion of gut, and buttoned the lower end of the ileum into the cæcum, the whole operation being performed without the least hitch and in the most expeditious way. When the surgeon left the side of the operating table he heaved a sigh and said, "I am afraid the child will not stand that." His fears were only too well founded. This leads me to ask one final question: Is it certain if after laparotomy we find an irreducible intussusception that a resection of the affected portion of bowel is the best available operation? This is a question I cannot attempt to answer myself; I only ask it in the hope that the surgeon will endeavour to answer it; for it seems to me that if a child has already got such a condition of strangulation of the bowel as is indicated by an irreducible intussusception, it certainly cannot stand much in the way of operation. Whether it is possible by leaving the intussusception outside the abdomen and making an artificial anus above the obstruction, or by submitting it to some less drastic operation than that which is involved in resection, to meet the requirements of the case, I do not know; but if it is I think the alternative should be tried.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Presentation to Mr. R. H. Jocelyn Swan.

Dear Sir,—I wish through the medium of your columns to thank all those students with whom I have had the pleasure of working during the last three years for the magnificent testimonial with which they have presented me. If you will be good enough to insert this letter in the "Gazette," it will convey to many who were unable to be present at the meeting my keen appreciation of their great kindness.—I remain, sir, faithfully yours,

R. H. JOCELYN SWAN.

Laryngeal Obstruction in Diphtheria.

Dear Sir,—With the aid of these notes of a few but consecutive cases of laryngeal obstruction in diphtheria I hope to be able to indicate the utility of intubation when properly applied in that condition.

In suitable cases the advantages of this operation as compared with tracheotomy lie in the nature of the operation itself, its remoter consequences, and its impression on relatives. This last is an appreciable advantage, as people who object to their children being "cut" will consent to intubation, and so relief, which would not otherwise be secured, can be afforded at a reasonably early period. It is an easier operation than tracheotomy and less to be dreaded by an anxious general practitioner whose opportunities for such surgical operations and means of obtaining outside skilled assistance are few. In contrast with tracheotomy it is easier on the living subject than the dead, and requires neither anæsthetic nor skilled assistance. Its remoter advantages consist in the absence of the common dangers of all incised wounds, of scars, as well as of a lessened likelihood of subsequent interference with the functions of larynx and trachea and in suitable cases a lessened chance of severe bronchitis.

Its special field is in purely laryngeal cases. In these obstruction may be urgent, but the retention of the tube for a few hours while antitoxin can take effect may be all that is required. It is contra-indicated in all cases with much faucial swelling, fœtor and apparent septic conditions where there may be either faucial obstruction or a septic focus which it is advisable to isolate from the

lungs. In other cases respiration through the natural channels is advantageous

Intubation has, of course, its drawbacks. It may fail to relieve obstruction, or it may be impossible to dispense with the tube, and for each of these conditions tracheotomy may be necessary. In view of the former eventuality the operator should always be prepared and have tracheotomy apparatus at hand, though they may be very rarely required. Inability to respire without a tube is a rare complication after careful treatment and likely to produce no bad result, and there is an immense difference between tracheotomy in a comparatively healthy and a seriously ill person. The condition may be the result of too long detention of the tube which may cause ulceration, and for this reason the tube should be removed after three days.

In my ten cases one was an adult of thirty-eight, in whom, after death, membrane was found extending to the bronchioles, so tracheotomy as well as intubation was futile. Intubation afforded some temporary relief and involved no risks or difficulties.

The other cases ranged in age from eleven months to four years, averaging under two and a half years; in one tracheotomy was preferred on account of the presence of mucus in the throat and faucial swelling; in another, intubation failed in its primary object, and as relief was not obtained, indicating obstruction lower down, tracheotomy was performed at once, while in one more this was done after a week, as attempts to leave off the tube were unsuccessful. The tube had been left in too long, five days in the first instance. The ultimate result was good.

In seven cases immediate relief was afforded, and in six of them the results were entirely satisfactory, the tube being removed in three days at the longest, after which there was no further trouble, and the seventh ultimately recovered. The only fatality was one due to complications following paralysis of the diaphragm three months later.

In four of these cases there was some bronchitis, in two very slight, and in none severe, so that the results leave little to be desired.

The general treatment of these cases was of a routine character. On admission, antitoxin was administered, evacuation of bowels secured, hot bath given, poultices applied locally. Subsequent to intubation the elbows were secured in extension with splints of cardboard and nasal feeding used while the tube was *in situ*. Before insertion of tube all preparations for tracheotomy should be made and the tube should be removed in three days, and the patient watched for at least half an hour afterwards lest any obstruction should return. With these precautions, not only in laryngeal diphtheria but in early laryngeal obstruction in measles, intubation should prove the satisfactory operation.—Yours truly,

J. N. GARDINER,
Plague Medical Officer, Punjab Club,
Lahore, India.

The Goblins.

TWELVE greedy Goblins, dating their Guy's career from the years 1892–94, assembled at the Café Royal on Tuesday, July 14th, and proceeded to justify their title under the impromptu direction of Mr. F. J. Lidderdale, stimulated by Mr. Putty Henry, the incarnation of Goblinism. Mr. E. S. Clowes, after having spent a whole year in preparing a presidential address, wired and wrote to say it was not yet quite ready, or words to that effect. The terms of his contract as President were therefore extended by one year. Mr. Henry might have had a look in for the presidential chair if he had not been such a good secretary; being, however, thereby disqualified, he was consoled by re-appointment to the secretariate. Mr. Hanson, although Vice-President, was unable to come, owing to urgent private calls; his term of office was also prolonged one year. Amongst those not absent were W. I. Hancock, E. D. Hancock, M. H. Way, R. P. Rowlands, P. W. Moore, E. I. Spriggs, W. E. Hills, R. P. Tilbury-Brown, H. Simson and F. E. Fremantle. The Bacillus Tilbury-Brownensis adorned the menu.

Mr. Lidderdale, in two masterly orations, proposed the healths of the King, and his Goblins far and wide. Mr. Spriggs covered himself with laurels in his rendering of "May Morning." Mr. Simson looked at a song and fled, Mr. Tilbury-Brown achieved a great military success with two noble patriotic songs. Sounds were also heard to emanate from Mr. Fremantle. Mr. Way confined his vocal efforts to an occasional chorus. Mr. Hills had left two old friends, in his banjo and his whistle, at home. A most happy and genial evening ended at midnight.

Change of Address.

Dr. H. Knight Rayson has moved from Lowestoft to 86, Osmaston Road, Derby.

Dr. H. J. Spon from 29 to 23, Southwark Bridge Road, S.E.

The address of Mr. Horace Croot, L.D.S., is 18, King's Terrace, Southsea.

Letters, etc., for Captain C. M. Fleury, R.A.M.C., should be addressed c/o Messrs. Holt & Co., 3, Whitehall Place, S.W.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Passim.

Once more we have to record a very admirable result in the examinations of the University of London. Mr. Cockcroft has gained the Gold Medal and Exhibition in Anatomy at the Inter. M.B., thus bringing us the honour for the second year in succession. Mr. Layton receives first class honours in the same subject, and Mr. Bookless also figures in the Anatomy honours list. Mr. Cockcroft, in addition to his Anatomy distinctions, has gained Physiology honours. To all of these gentlemen we offer hearty congratulations. But not to them alone; there are the others in the humbler, but none the less useful pass list, who swell our percentage of passes to seventy-six. The Preliminary Science list is not yet published, but we sincerely hope, and confidently believe, that its appearance will still further establish our claim to be the premier college of the University.

There seems a special fitness in the arrival of these distinctions at a time when the centralization of preliminary medical training is beginning to take shape. One is naturally led to ask what good we shall derive from the transference of our teaching obligations to the hands of a central authority. There can be no doubt of our efficiency. We have but to appeal to the published pass lists to demonstrate that while we maintain an excellent average, in the past year, for example, 85 per cent. passed, the massed totals of the other schools show the accustomed pass percentage of 45. It is contrary to the established facts of teaching experience to assert that classes are of equal efficiency to individual tuition. Similarly the efficiency of a class varies inversely as the number in the class. Hence, any move in the direction of concentration must be ultimately to the harm of the general standard of knowledge. And since we claim to give our men the best preliminary education, we can reasonably claim to fit them most capably for their work in the wards. The final and logical deduction from these premises is that centralization will tend to spoil the finished article with results that must ultimately recoil on ourselves.

Perhaps the most eccentric action of the University is in connection with the Inter. M.B. examination. We have already groaned under the injustice of the new conjoint M.B., B.S., which destroys at once the peculiar value which had attached to the B.S. Lond. In the case of the London Hospital, it was specified that candidates for the post of Surgical Registrar should be F.R.C.S. Eng. or B.S. London. Such a stipulation showed that in the eyes of one governing body at least the degree ranked next to the premier English qualification in surgery. However, that distinction has gone by the board, and the men who have gained the degree under the old régime are forced to grin and bear the inevitable martyrdom of the minority in the march of progress.

To return to the Inter. M.B. Every graduate of the University will remember the real difficulty of that examination. To some it was given to pass at the first time and in the first division, but even they can scarce deny to their frailer brethren the comforting assurance that the examination is "stiff." Much of this "stiffness" lay in the inability of the examiners to appreciate that their own particular subject was not the sole reason of the examination. A little more concerted action on the part of the inquisitors might have relieved the test of much of its unfairness, and left it the whole of its soundness. However, at last it has appeared good to the Senate that the severity of the examination should be reduced, and the method adopted is Gilbertian in its ludicrousness. Following the train of thought which led the old lady in the carrier's cart to place her heavy basket on her lap because the horse had already enough load to pull, the organic chemistry section has been transferred *en bloc* to the preliminary scientific examination without any extension of the time allowance whatever. Old London men will appreciate the futility of attempting to stuff the young idea with organic chemical lore before it has digested the more assimilable inorganic section.

The result of this change can be predicted with absolute certainty. Instead of taking a year over

the Pre. Sci., and two years over the Intermediate, men will be forced to spend eighteen months or two years over the first examination without any compensatory decrease in time for the second. And thus, in the views of the Senate, more men will be attracted to the course. The second act of this comic opera discovers the men who have passed the Pre. Sci. under the old regulations about to attack the chemistryless Inter. M.B. But stay, they are discovered. One watchful clerk has given the alarm and a new and awful barrier arises. Unless they can pass a special examination in Organic Chemistry (with a special fee) by next July, they must pass the Pre. Sci. over again. This is actually set forth in the official organ of the University. A more outrageous, a more idiotic demand has never been made even by London University. Assuredly this body stands without a rival. Long may it be so.

Mr. Dunn made a very welcome reappearance at Guy's on Thursday last after his illness. The cordiality with which he was received will assure him that he has not lost any of the affection of the men who have worked with him and enjoyed his friendship.

We should like to call attention to the notice of the Physical Society asking for papers to be read at the ensuing session. Strictly speaking, the titles of such papers should have been submitted by yesterday, but the Physical Society is of such venerable age that it can afford to permit a certain amount of licence without loss of dignity. It does not appear to be generally known that the society admits discussion on general scientific subjects only remotely connected with medicine. It is true that of late the subjects on which papers have been read were appreciable only to the men with some ward experience, but it is well within its constitution to promote debates on matters that can be appreciated by men in the dissecting-room. The society is old and very honourable, and it behoves the youngest and the oldest Guy's man alike to uphold its position. It is hoped that the ensuing session will see a renewed interest in the Pupils' Physical Society.

With this number we are issuing a photograph of the Trophies now in the possession of the various clubs. It will be noticed that the number is one more than was mentioned in our last issue. This is due to the inclusion in the group of the Cricket Cup which was won outright in 1888. If possible, we shall publish a massed photograph of the winning teams later in the year. It may perhaps be urged that we are giving an undue prominence to our athletic achievements. We cannot think so. The year is undoubtedly a record in athletics, a record moreover which will take an enormous amount of beating. Add to this the remarkable professional successes of our men and we think we have sufficient excuse for laying great stress on this exemplification of the old saw "mens sana in corpore sano."

The hundred and fifty-second Annual Report of the Pennsylvania Hospital is a most admirable example of thoroughness in every detail. Judged by the standard of London Hospitals, the Pennsylvanian is a comparatively small institution, with plenty of available capital, and therefore well able to issue the exhaustive abstracts which appear in this volume. It makes one's mouth water to read the balance sheet with its cash balance of forty-five thousand pounds. We are so accustomed on this side of the water to see an overdraft figuring in the balance sheet that it is difficult to believe a hospital can exist with two hundred thousand dollars lying idle in the bank. One line in the list of cases treated in the receiving wards might well be taken to heart in London. It chronicles three hundred and thirty-nine cases of alcoholism. Pennsylvania apparently has long appreciated the necessity of "drunk or dying" wards.

An appeal to Guy's men has been issued by the Rev. C. H. Bowden, of St. Paul's Church, Bermondsey, on behalf of the Restoration Fund of the church. As Mr. Bowden points out in his letter, the demand for funds is not prompted merely by a praiseworthy desire for a clean and properly appointed building, nor even to make good some minor ravages of time. It is an appeal to preserve the very existence

of the church which has brought upon itself the condemnation of the London County Council, and stands scheduled as a "dangerous building." Two thousand pounds are required to defray the cost of the immediate and urgent repairs, while another fifteen hundred pounds must be spent before the church can be worthy of its name. Mr. Bowden, as an old Guy's Chaplain, appeals to Guy's men to help him in this difficulty, and points out that even as Guy's men contributed largely to the building of the church in the first instance, so he hopes that they will again help in the present crisis.

The examinations for commissions in the Royal Army Medical Corps are now on, and have claimed a good share of our men. With a view to test the actual practical value of the men, to gauge the permanent residuum after the examination cram-stuff has been squeezed out, the examinations have been framed with a very large degree of skill and care; and if one may judge in the present stage, they have succeeded. The avowed aim of the tests was to enable a well-educated, sound man to pass without any special reading. Commentaries and practical work, *viva-voces* and clinical examinations, and an absence of set papers have rendered this possible. So the candidate is searched in the depth of his real knowledge of his profession, and no attempt is made to probe his grasp of the geological formation of Switzerland, or the comparative legginess of the centipede. For the first time in its history, the Indian Medical Service has taken second place to the R.A.M.C.

We have received a copy of the "Handy Hotel Guide for 1903-4," with a request for a review. The value of a guide such as this may be deduced from three statements on three successive pages: On the cover, "price twopence." First page, "Copies of this Guide may be obtained (gratis) from any of the Hotels recommended therein." Next page, "This is not a mere collection of advertisements. No charge has been made for the recommendation of any Hotel." Comment is superfluous.

Pass List.

University of London, July, 1903.

INTERMEDIATE EXAMINATION IN MEDICINE.

EXAMINATION FOR HONOURS.

First Class.—Anatomy.—G. Cockcroft (Exhibition and Medal), T. B. Layton.

Second Class.—J. S. Bookless.

Physiology and Histology.—Third Class.—George Cockcroft.

ENTIRE EXAMINATION.

First Division.—W. H. Trethowan.

Second Division.—E. Alban, A. W. Berry, C. C. A. De Villiers, E. C. Lowe, P. F. McEvedy, W. H. Miller, P. S. Mills, H. F. Vandermin, T. F. Wilson.

Physiology only.—P. C. P. Ingram.

Second Conjoint Examination, July, 1903.

G. F. E. Allison, W. H. S. Burney, A. W. Eyles, P. C. Litchfield, E. Morgan, H. H. Moyle, C. M. Ockwell, S. Reader, R. J. Reynolds, G. Wacher.

Papers by Guy's Men.

An Inquiry into the Susceptibility of Criminals to Atmospheric Changes. By W. Norwood East, M.D. Lond., M.R.C.S., L.R.C.P. Lond.—*The Lancet*, July 25th.

On the Desirability of Operating for, and the Mortality from Chronic Pancreatitis. By W. Hale White, M.D. Lond., F.R.C.P.—*British Medical Journal*, July 18th.

From the Gazette's Special Pathologist.

Directions to be followed in sending *Diphtheriti Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

NOTICE.

G., Windlesham.—No tubercle bacilli were found in this sputum which was purulent in character. Streptococci were, however, present in considerable numbers.

PATHOLOGIST.

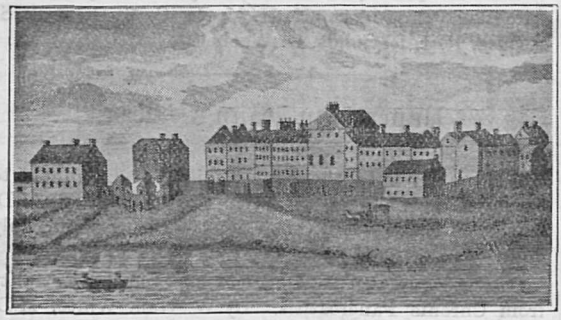
Historical Notes on Haslar and the Naval Medical Profession.

THE HOSPITAL.

HASLAR is the Royal Naval Hospital at Portsmouth, and the largest establishment of its kind in the world.

It was erected between the years 1746 and 1762 at the "earnest recommendation" of John, fourth Earl of Sandwich, the then first Lord of the Admiralty, who obtained a vote to construct a hospital at Portsmouth in 1745, in which year the land was purchased. The word "Haslar" is said to be a corruption of Hazelwood, which was the name of a farmer who previously owned a farm there.

Before the present hospital was erected, there was apparently another one in Gosport called Fortune Hospital, founded by one Nathaniel Jackson, who contracted with the Commissioners (of the Admiralty). This was furnished by them with 700 beds for the treatment of sick and wounded seamen.



Haslar in 1790.

Before 1750, however, it is probable that sailors were chiefly treated in civil hospitals or in lodgings.

The present hospital at Haslar forms three sides of a square: the original plan included a fourth side, but it has been omitted in the completed building, and this is held to be an advantage since, being the S.W. one, it allows greater access of sun to the rest of the building.

It is constructed of red brick with white stone facings, in the style which is known as the palatial system, and is modelled after a part of Greenwich Hospital, which was designed by Inigo Jones. Mr. John Turner was the architect.

Over the main entrance is a fine sculpture in Portland stone carved by Mr. Pearce, representing the Royal Arms, with the figures of Navigation (on the left) and Commerce (on the right), the former leaning on a rudder and pouring ointment on a wounded seaman. The letters G. II. R. are carved on the upper part. The central block over and about the main entrance contains the Receiving Room (where patients are first admitted), Telephone Office, Inspector General's and other officials' Offices, Surveying Room (where men are examined as to fitness for further service, etc., and which contains a curious old painted Royal Coat of Arms dated 1706) and Bath Rooms. Above are wards, Rontgen-Ray Room, "Duty Cabins," Operating Rooms, "Dark" Room for examining throats and eyes, Dental Room, Mess Rooms for Sick Berth Staff, and right at the top the extensive hospital Kitchens.

All the interior is modernised and thoroughly up to date. Formerly there was a spacious hall here, at first used as a chapel and later apparently partly as the agent's store and partly as apartments of surgeons. All this has again been changed as above.

On each side of this block extend the general wards in double rows, separated by a considerable space, which allows of the entrance of light and air.

At the present time there are 63 wards opened, capable of accommodating 1094 patients—on occasion 1800 or more (McGrigor mentions 4000!) have been taken in. Of these 63 wards, 61 are oblong averaging $60 \times 24 \times 11$ft., and furnished, as a rule, with 14 beds each.

The upper wards are a little wider (owing to the walls being thinner), but not so lofty as the lower ones.

The walls are immensely strong and so are the foundations, it being popularly said that there are as many bricks below ground as there are above. It is also said that all the bricks of which Haslar is built were made on the spot.

Nearly all the wards are named after some celebrated naval commander, and they are also numbered, the odd numbers being on the medical side (in the southern wing) and the even numbers being surgical wards (in the northern wing).

It may briefly be said that the sanitary arrangements in all the wards are excellent and quite up to date.

The fourth side of the square is filled in with lofty iron railings, having in the centre a gateway leading to the little unpretentious chapel, which was built in 1762.

Behind the chapel lie the "airing-grounds," and at the far end of these, the Terrace, erected in 1796–98, and containing residences for the Inspector-General, Chaplain, Head Dispenser and other officials.

The hospital building occupies 7 acres, the "airing-grounds" (so called because the convalescents take the air there) 33 acres, and the whole is surrounded by a high brick wall. Altogether the enclosed land amounts to 46 acres.

The Haslar land proper is far more extensive, and extends over 95 acres, including the large field now used as a playing ground for the boys from the training-ship "St. Vincent."

Haslar forms a complete little community in itself, containing, besides the above-mentioned buildings, other old official residences, probably as old as the hospital itself, quite modern quarters for surgeons and nursing sisters, a bran-new Zymotic Hospital for infectious fevers, a large dispensary, a good water supply (with

Chess Shield.

Cricket. *Cricket (won outright in 1888).*

Junior Cricket. *Junior Association Football.*

Cross-Country Vase. *Armitage (Shooting) Cup.*

Rugby Union Cup

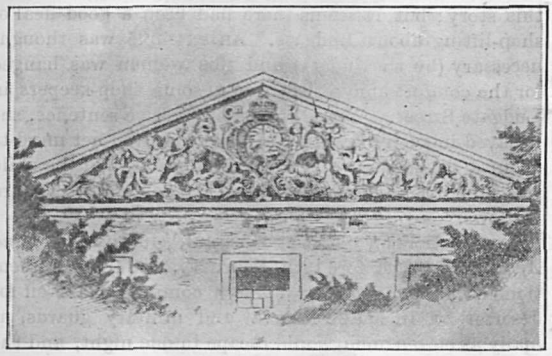
Bisley Cup. *Association Football Cup.*

Inter-Hospital Challenge Trophies held by Guy's.

two deep wells, engine-house and water-tower, which latter is 120 feet high and forms a land-mark for miles around), a modern steam laundry, a well-fitted laboratory, a most valuable museum and medical library, and last, but not least, two little railways to itself for conveying patients from the landing jetty to the general and infectious hospitals. This jetty is situated on Haslar Creek, an arm of Portsmouth Harbour, up which the patients have to be brought by the special hospital steam-boat from their respective ships.

In olden time (Henry VIII.'s reign) Haslar Creek was called Ostrepool Lake (Oyster Pool Lake) because there was a bed of oysters there, and in the early part of last century it is recorded that a large whale found its way into the creek, where it was stranded and killed. It took six horses to drag it ashore.

About 200 yards higher up the creek from the jetty stands Haslar Bridge, which still exacts a toll from the passer-by, a state of things which, existing in this year of grace 1903 (and apparently in the middle of a public thoroughfare), is looked upon by the antiquarian



The carving over the front entrance.

as an interesting link with the Dark Ages, but by the vandal as a decidedly unfair imposition, since in order to avoid the expense, the traveller to Haslar must wend his weary way some three miles round the head of the creek. However, it is an ill-wind which blows no good to any man, and I have heard that the bridge company pays a good dividend. But this is by the way!

The present bridge was built and opened in 1835, and previous to this, since 1801, the passage had been effected by ferry boats. Before this, again, there had been a wooden bridge called Forbes Bridge.

Running down the creek from the jetty is a spit of land, Blockhouse Point, at the extreme end of which stands Blockhouse Fort, forming the southern guard to the entrance to Portsmouth Harbour, from which in bye-gone times great chains extended to the opposite side of the water. These chains were tightened in times of danger, by means of capstans, and thus served to protect the harbour from hostile fleets. They were last used in 1778.

On this point also formerly stood a gibbet on which the bodies of local criminals were hung as a warning to evil-doers. Jack the Painter, who set fire to Portsmouth Dockyard, was gibbetted here. The last time it was used was in 1780.

In Howard's "Lazarettos of Europe," published in 1791, there is the following account of "The Royal Hospital at Haslar near Gosport": "I always found this well-conducted hospital remarkably clean and quiet, and (what is very different from the practice in the county hospitals) none of the floors were sanded or dry-rubbed, and the windows on all the staircases were open. (Dr. Lind long since informed me that he had the sash windows on the staircases nailed up in the summer to prevent their being shut.) The patients have white linen shirts; and the hospital clothes and the linen of the beds are white. In this hospital there are about eighteen hundred beds, nineteen or twenty in general in a ward. The wards are sixty feet by twenty-four, and the height twelve feet on two floors, and ten feet on the third, and the arcades below are twenty-four feet wide. All the nurses here and in the hospital at Plymouth are women, which is very proper, as they are more cleanly and tender, and they more easily pacify the patients who are seafaring men. Visitors are admitted, very properly, only on two days a week. The staircases are spacious, but they are of wood; the rises are too high, and there is no hand-rail on the wall. The inside sewers are offensive; there are no cisterns in the wards. The two cells for lunatic patients are too close and badly situated. The ceiling of the attic floor is too low. To each wing there should be a sea-bath." Further slight criticism follows, and the article is embellished with an excellent plan and front elevation of the hospital.

Howard, the philanthropist, mentions the "spacious" staircases: they still present one of the finest sights in the hospital, with their handsome old oak balustrades, which, polished by age and long use, are said to have called forth a remark of admiration from our late Gracious Majesty, Queen Victoria, when she inspected the hospital.

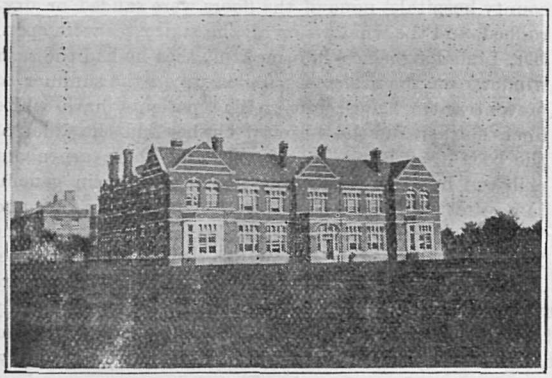
Dr. Thomas Trotter, M.D., Physician to the Fleet, in his book entitled "Medicina Nautica," vol. i., published in 1797, says that at this time there were no baths in Haslar—tubs were employed for this purpose, "but the seamen had such a dislike to them, that it was found impracticable to get a rheumatic patient to bathe, because they reminded them of *scrubbing* by way of punishment on board."

Trotter further remarks, "a sailor under disease ought to be bathed like a gentleman." He was evidently a fine old gentleman, who had great hopes in the future of the Naval Medical Service. "In a hospital like Haslar I think the practice of the medical profession might be carried to a higher degree of perfection than in any other in Europe, and the pure spirit of science made subservient to the treatment of the objects it is intended to relieve, beyond what can be done anywhere else. If I am thought to be singular or Utopian in this opinion, I have no objection to stand alone."

There is one more passage from Trotter which I must quote verbatim :

"On September 30th, 1795.—This day Earl Spencer, accompanied by Lord H. Seymour and Mr. Pybus, Lords of the Admiralty, honoured the Charon hospital ship with a visit.

"Next day their Lordships surveyed Haslar Hospital and marked out the ground for erecting the houses for a governor, lieutenants, and other officers, about to be



The New Surgeons' Mess.

added to this institution, in consequence of a general enquiry by two flag-officers, and two Captains of the Fleet, made in March, 1794, at my representation."

The houses referred to are those which now form the Terrace.

THE PATIENTS.

The first patients were admitted to Haslar in 1754; and a pretty motley crowd they must have been, for there was no uniform laid down for seamen until more than one hundred years later; and very often men were sent from ships in a shocking condition—sometimes, indeed, with hardly any clothes on at all.

Few sailors then lived to be old, it was too hard a life.

According to Trotter, the British sailor was, as a rule, a fine, bold, free-and-easy, happy-go-lucky fellow; but occasionally he was detected malingering; "hence he employs caustics to produce ulcers, and drinks a decoction of tobacco to bring on emaciation, sickness at stomach and quick pulse."

He also speaks bitterly of the evils of impressing, as causing—and naturally—"a species of mental affliction —without any apparent disorder." It is not to be wondered at, that being impressed into the service against their will, patients at Haslar often attempted and sometimes effected their escape. Poor wretches! who can blame them for trying to regain their freedom, which meant in many cases return to their wives and families.

The melancholy side of this fearfully rough and ready age will be brought forcibly home to the reader by the following narrative, related before the House of Commons, in a speech by Sir William Meredith in 1777 : "Under the Shoplifting Act, one Mary Jones was executed, whose case I shall just mention. It was at the time when press-warrants were issued on the alarm about Falkland Islands. The woman's husband was pressed, their goods seized for some slight debt of his, and she with two small children turned into the streets a-begging. 'Tis a circumstance not to be forgotten that she was very young (under 19) and remarkably handsome. She went to a linen-draper's shop, took some coarse linen off the counter and slipped it under her cloak. The shopman saw her, and she laid it down. For this she was hanged. Her defence was 'that she had lived on credit and wanted for nothing, till a press-gang came and stole her husband from her; but since then she had no bed to lie on—nothing to give her children to eat—and they were almost naked; and perhaps she might have done something wrong, for she scarcely knew what she did.' The parish officers testified to the truth of this story; but it seems there had been a good deal of shop-lifting about Ludgate. An example was thought necessary (by the judges) and this woman was hanged for the comfort and satisfaction of some shop-keepers in Ludgate Street. When brought to receive sentence, she behaved in such a frantic manner as proved her mind to be in a desponding and distracted state—and the child was suckling at her breast when she set out for Tyburn Gallows."

In an article on "Haslar Hospital," in the *Navy and Army Illustrated* for 19th February, 1897, it is mentioned that in 1755 Haslar was a common "take-off for deserters." In spite of naval and military guards, as many as eleven men would escape in one night, and the main drain opening into Haslar Creek was, at low tide, evidently a frequent means of exit for these poor wretches. To my mind, it is a marvel that the place was not demolished "en masse," when the method adopted for recruiting the Navy was so brutal.

Here is another yarn of the atrocities of press-gangs, related in the "Life of Thelwall":—"As a vessel was coming into the port of Poole, the few hands on board saw a press-gang making towards them. The whole of the crew determined to resist. Notwithstanding, the captain of the gang boarded the vessel, and succeeded in conquering the unfortunate seamen. In the struggle two of the seamen were shot dead, upon which the young mate, seeing his men overpowered, wounded and killed, in a fit of frenzy, bared his breast, exclaiming 'You have murdered my companions, murder me also.' The ruffianly lieutenant took him at his word, and coldly and deliberately levelling his pistol, shot him through the heart."

The iron railings erected on the fourth side of the square at Haslar were put up in 1795 in order to check these frequent desertions and at the same time the lower windows of the hospital were barred, and the wards kept

locked at night. Compared to those times, the blue-jacket of the present day may indeed consider himself well off, for as a patient in Haslar he certainly has not much to complain of, and to give him his due, he is generally a well-contented patient.

Many other nationalities besides British have been treated in the wards of Haslar. It is recorded that in 1796 a number of Portuguese from the Portuguese fleet was sent to Haslar with typhus, and among others, French prisoners (many of whom were confined on board a hulk at Porchester) and Turks (there was a Turkish burial place where part of the new infectious hospital now stands, and this was transferred bodily to the new cemetery when the ground was wanted).

Although the seamen of those days more often than not had a very rough time of it, it must not be imagined that they were altogether badly treated: had the above example been very common, it is certain that the British Navy would have ceased to exist. There is a brighter

Dr. James Lind, R.N.
Physician to Haslar Hospital.

side to the state of things existing a century ago. Thus we read of captains who took an interest in their crews, ordering various games, books, etc., for them. "Captain Charles Thompson ordered the people of the *Vengeance* 'tops' by way of exercise, when we approached the cold weather, on our passage home."

Apparently, if we may judge by the characters in Marryat's and Smollett's novels, the naval officer was frequently a pretty queer customer, but about the year 1790, many young men of the first families, following the example of the Duke of Clarence (afterwards William IV.) began to flock into the Navy. One ship in particular was remarkable for having a great many of these young sprigs of nobility. These young ones were accustomed to reef and furl the mizen-topsail. One day when they were aloft furling sails, the captain thus addressed them from the quarter-deck:—"My Lords and Gentlemen, and you Right Honourable Lubbers, on the mizen-topsail-yard, roll that sail up, and be d———d to you, and come down."

The most prevalent diseases in the Navy then were typhus and scurvy. Some ships would send as many as one hundred cases of typhus to hospital, and in 1795 it was feared that the whole Channel Fleet might be rendered inactive from the ravages of scurvy.

The following sick list of men taken ill in His Majesty's ship *Colossus* for June, 1795, is instructive:—

Fever	3
Flux	1
Catarrhal complaints	6
Scurvy	60
Ulcers	1
Other diseases	4
Wounded men, etc., 23rd June ...	53
Total	128

Besides this, the following passage from an old naval doctor writing in 1797, may be mentioned as throwing a lurid light on the Navy of the time:—"The treatment of the drunken paroxysm or a fit of intoxication is the most frequent part of a navy surgeon's duty." Nowadays, the blue-jacket is, as a rule, a well-behaved and orderly patient—he is keenly alive to his own interests, and apt, though very occasionally, to make ungrounded complaints about his diet and so forth; he does not stand pain, as a rule, so well as the London costermonger, but that is because being better fed and looked after, his nerves are the more sensitive. On the other hand, one sometimes meets with instances of extraordinary pluck during pain.

Thus on one occasion the writer had to remove a loose cartilage from the knee-joint without chloroform, and on another it was necessary to amputate a finger without a general anæsthetic. During the latter operation the patient bit a piece of indiarubber, but in both cases the pain was borne without wincing.

With the blue-jacket, more than with any other class of patient, has the mental factor to be reckoned. I have met with great, young, powerful giants as hysterical as a weakly young girl; and these were genuine cases and not impostors. I suppose that the peculiar and often trying conditions of life in a ship are responsible for this fact—and I firmly believe that home sickness is as real a disease in some cases, as typhoid fever. Mind you, in saying this I do not in any way mean to disparage the blue-jacket of the present day. I have indeed a great admiration for him—and especially for the "bad-hat" have I a lurking regard, for troublesome as he is at ordinary times, in a "tight corner" he generally turns up trumps.

A shipmate of mine once spun me the following yarn:—"The ship I was then in, during a storm, had run on to some rocks on the coast of Newfoundland, and in the heavy sea running, it was evident she must soon break up. Our only chance was to get a life-line rigged to the

beach, so a volunteer was asked for to attempt the almost impossible feat of swimming ashore with a line. The 'bad-hat' of the ship volunteered, and after having asked for a bottle of brandy and swigged it off, plunged overboard and managed to get to the shore, and as a result we all escaped what was almost certain death. We all got ashore by means of the life-line except the ship-steward's boy, who was too frightened, and in a frenzy of terror jumped overboard; we made certain he was lost, but we found him next day, though how he managed to get through that sea I can't imagine."

Yes, the blue-jacket is a peculiar mixture, but most of his faults—and they are many—may be put down to the peculiar circumstances under which he serves his country; he is not bad at heart. And the same may be said for his brother—the "soldier and sailor too"—Joey the marine.

NAVAL MEDICAL OFFICERS.

When I mention such names as Dr. Lind, Sir Gilbert Blane, Dr. Trotter, Professor Huxley, Sir Andrew Clarke, Sir Dyce Duckworth and Sir J. D. Hooker as occurring at one time or another in the Navy List, I need ask no excuse for this chapter. Every naval medical officer is a unit of a profession, the capacity of which for saving life is more than that of all the heroic naval and military commanders, past, present and future, put together, so that the subject appears to me deserving of some little notice here, especially as Haslar may be looked upon as the headquarters of the department. I do not write thoughtlessly, because disease is always more terrible than war *per se*, the truth of which statement was recognised many, many years ago.

A Naval Doctor in William IV's Reign (epaulette on right shoulder, scale on left—red facings—bullion on hat).

I will quote Sir Gilbert Blane from his "Health of the Royal Navy," published in 1830, dedicated to William the Fourth.

"After my return to England in the year 1783 I was enabled, from my own notes, and from information derived from the official records at the Navy Office, and at the Office of Sick and Wounded Seamen, to make out a statement of the whole loss of lives in the fleet in which I served as physician, from the beginning of 1780 till April, 1783, a space of three years and three months. It came out as follows:—

"Died of disease	...	...	3,200
Killed in battle	...	...	640
Died of wounds	...	...	500
Total	..	...	4,340

"It is a very general and true remark, that in war more perish by disease than by the sword: in the present case the proportion is about three to one. We find the same remark made by ancient historians."

So little is known historically of the naval medical officer—and what little there is, is so interesting—that I am venturing to give a few outlines here, although as much of the time is prior to 1750, there is no direct connection with Haslar.

I ought to say that I am indebted for many facts now mentioned to a most interesting pamphlet by Dr. W. R. E. Smart, C.B., Inspector-General R.N., reprinted from the *British Medical Journal* in 1874.

There is reason to believe that some men of good surgical repute devoted themselves to sea-service as early as Queen Elizabeth's reign.

In Henry the Eighth's reign, the King owned the ships in his first fleet, and he entered on an agreement by indenture with Sir C. Howard to man them. This indenture specifies only two classes of men (1) masters or captains, (2) common men. This shows that surgeons were rated and paid as common men. Probably, however, naval surgeons of this time were not of any great social standing, for, speaking of army surgeons, Dr. Smart quotes Thomas Gale, who wrote somewhere about the middle of the sixteenth century, "I remember when I was in the wars at Montreuil (1544), there was a great rabblement there that took upon them to be surgeons. Some were sow-gelders, and some horse-gelders, with tinkers and coblers."

According to William Clowes, some time naval surgeon and finally surgeon to St. Bartholomew's Hospital, and to Queen Elizabeth, writing in 1596, there were many

worthy men, but also many scamps, in the naval medical service—if such it can be called—in those days.

The entire management of medical affairs of the navy appears to have been placed in the hands of the Company of Barber-Surgeons of London. In a letter written on 23rd March, 1635, from the Navy Office to the Admiralty, is found the following:—"The fleet now drawing and ready to goe to sea, we have according to the ancient custom given orders to the Masters and Warders of Barber-Chyrurgeons, to press chryrurgeons for all the

An Assistant Surgeon in the "sixties."

ships of the first fleet, and have given them charge to cause them to appear before us, att the Meeting House in Mincing Lane, on Fryday in the afternoon, the 1st of Aprill."

Dr. Smart considers that William Clowes may perhaps be looked upon as the first "Medical Director General." His successor was one John Woodall, at one time Surgeon-General of the East India Company, and appointed by Charles I.

Surgeons then, being neither masters nor captains, were rated as common men until 1704, when they first became warrant officers together with pilots, boatswains, gunners, and carpenters; and, according to Robinson, "at some time in the eighteenth century, but . . . "not officially until the issue of the regulations of 1808, masters, surgeons and pursers received the title of 'warrant officers of ward-room rank,' and were thus differentiated from the boatswain, gunner and carpenter."

It must be remembered, however, that in those days a surgeon was a somewhat senior officer, and the juniors or assistant-surgeons had to remain content with hammocks, and gun-room fare and company until about the middle of the nineteenth century, a state of things which was a fruitful source of grievance.

The surgeon's mate of Smollett's day held a very inferior position—as a favour he might be allowed to mess with the warrant officers.

Nowadays all naval doctors are commissioned officers of ward-room rank, and the titles are as follows:—

Director-General.
Inspector-General of Hospitals and Fleets.
Deputy Inspector-General of Hospitals and Fleets.
Fleet-Surgeon (after 8 years as Staff Surgeon).
Staff Surgeon (after 12 years as Surgeon and Examiner).
Surgeon.

Deputy Inspector-Generals are promoted by selection from Fleet-surgeons, and Inspector-Generals again by selection from the Deputies.

In 1842, the naval medical ranks and titles were:—

Inspector of Hospitals.
Physician.
Deputy-Inspector of Hospitals.
Surgeon.
Dispenser.
Assistant-Surgeon.
Acting Assistant.

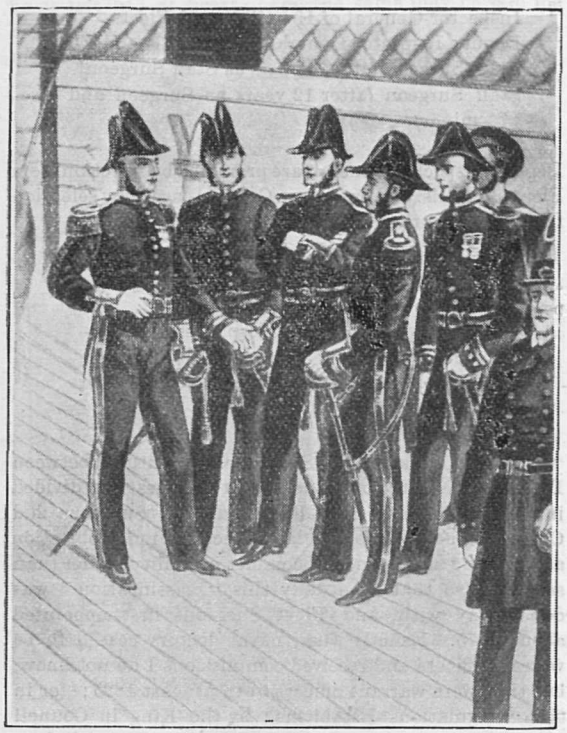
Later the rank of Staff Surgeon was instituted between Deputies and Surgeons, and then this class was divided into Staff Surgeons 1st Class, and Staff Surgeons 2nd Class, although this nomenclature received much objection as implying a difference in conduct or ability rather than seniority, so that eventually this "classification" was done away with, and Fleet Surgeons first appointed about 1875. Exactly when naval doctors ceased to be warrant officers and received commissions I do not know, but they were warrant officers until at least 1825; for in the "Regulations Established by the King in Council for His Majestie's Service at Sea, MDCCCXXIV.," we find:—

"The following are the denominations of the warrant officers and the order of their respective ranks:—

Masters.
Secretaries.
Physicians.
Chaplains.
Surgeons.
Pursers.
} To rank with Lieutenants in the Navy, but subordinate to them.
Second Masters.
Assistant-Surgeons.
Mates.
Gunners.
Boatswains.
Carpenters."

Naval Medical Officers, as a rule, are an unpretentious class of men, but in a quiet plodding sort of way they have done not a little good work.

Naturally scurvy was the first disease to attract their attention and special work. Thus, as early as 1696, William Cockburn, Physician to the Royal Navy of Great Britain, published a work entitled "Sea-diseases, or A Treatise of their Nature, Causes and Cure." In this he enters into detail especially as regards the disease scurvy. Through his exertions many were cured, but the author regrets that this "distemper" had as yet been left without a remedy at sea. He was evidently a keen observer, and points out that "refraining from



A Naval Doctor in the middle of the Nineteenth Century (1869).

the sea diet, and living upon green trade (as it is called) on shore proves an absolute cure." (Green trade means vegetables.)

In the middle of the next century, the truly great Dr. James Lind was doing sound hard work for sick and disabled seamen — such as should render his name honoured and venerated for all time. He has been well called the "Father of Naval Medicine," and must have spent very many years in the service, for his first work that I can find (on "The Scurvy") was published in 1757—and this was the second edition—and he was senior Physician to Haslar Hospital in 1799, on the magnificent salary of £300 a year!

Here it will be interesting to give the earliest published list of residents in Haslar, from the "Navy List" for January, 1799:—

Royal Hospital at Haslar, near Gosport.

W. Yeo, Esq., *Governor*, 500*l.* per ann.

Lieutenants: T. Parke 1st, A. M'Gregor 2nd, H. Blaxton 3rd, 130*l.* each. *Physicians:* J. Lind, 300*l.*; R. Hope and A. Thompson, 250*l.* *Surgeons:* T. FitzMaurice, 230*l.*; C. Dods and J. Stephenson, 200*l.* *Steward:* J. Merritt, 150*l.* *Agent:* G. Mottley, 150*l.* *Dispenser:* W. Richardson, 150*l.* *Chaplain:* J. Hall, 150*l.*

In those times, and indeed until quite recently (April, 1870), besides the Medical and other Officers of the hospital, there were also (as will be seen above) various executive officers appointed, in order apparently to keep up the discipline of the place.

Some of the old Governors—or Captain-Superintendents as they were also called—must have been funny old men to deal with, as the following anecdote from "The Autobiography of Sir James MacGrigor" goes to show. Sir James was Inspector at Portsmouth in the Army Medical Department at the time (1808), and a great part of Haslar had been lent by the Admiralty to the Army for the accommodation of their numerous patients. (It was just when the remains of Sir John Moore's army had returned "with an overwhelming number of sick and wounded." Typhus was rampant.)

"Two deputy-inspectors of hospitals were sent to Portsmouth to act under my orders. I appointed one of them for the inspections afloat, the other for those on shore, especially for the naval hospital at Haslar, which we had obtained possession of only on condition that we should strictly conform to all the rules of naval discipline (and this was intimated to us in such a way as though they feared a breach of it), and that the utmost deference and respect should be paid to the naval captain at the head of the hospital, who was styled 'Governor.' I inculcated on Mr. Hogg, the deputy-inspector at Haslar, that he should impress on all the young medical officers the utmost respect towards this personage, and that he would see that the externals of respect, which I knew the 'Governor' rigidly looked for, were most ceremoniously paid to him. In no long time I found that the young medical officers, having become acquainted with the character of 'His Excellency the Governor' of the hospital, rather exceeded in the externals of respect towards the old gentleman, and received him with much mock state, which, however, he for some time received most graciously, until he found out that this marked respectful demeanour was shown in derision. He then complained to General Whetham, and said that, by the introduction of these young army doctors, the discipline of the hospital would be destroyed, and that he would never again be able to bring the medical officers of the navy to a due sense of the respect they owed him.

"One of the standing orders of this dignified personage was that on entering the gates of the hospital every military as well as naval officer should have his name taken down by the porter in a book, with the precise hour and minute of his entry, so that his Excellency should be acquainted with all the movements of each individual.

"Another of his orders was to this effect—that every medical officer should touch his hat to him every time he saw his Excellency, however often that might be.

"Two very young Irish assistant surgeons had somehow been wanting in this mark of respect for the Governor, of which he made a formal complaint to General Whetham, and the complaint was conveyed in such terms that I was sent with General Porter, second in command of the garrison, to explain and to pacify the Governor. We had some difficulty in keeping our countenances during the time we executed our mission to his Excellency. I called the medical officers together and explained to them that, while we were indulged with the use of the naval hospital for the soldiers, we must conform to all its regulations, and that the utmost courtesy must be paid to the Governor. This was caught up immediately and carried into execution in its most literal meaning.

"On the following day, and for many days afterwards, the medical officers assembled in the court-yard of the hospital, and awaited the appearance of the Governor, when they formed a line on each side of the path through which he had to pass, and as he passed through the line, all were instantly uncovered. This was understood by him as a mark of perfect respect, and as he passed through the line he smiled most complacently, bowing on each side very graciously. On another occasion, he called for higher honours than the military guard at the hospital paid him, and he insisted that, besides the guard turning out to him when he passed, he was entitled to a march by beat of drum. The sergeant came up to the young Irish officer who commanded the guard for instructions, and he instantly told him to beat 'the Rogue's March, which quite satisfied and delighted his Excellency, he not knowing the kind of air which was played to him, although every man of the guard was almost suffocated with laughter. But the beating a march was never repeated."

Dr. Thomas Trotter, the author of an extremely interesting book entitled "Medicina Nautica," entered the Navy at Christmas, 1778, as a surgeon's-mate: he quickly rose, for in the "Navy List" (Steel's original and correct List of the Royal Navy, hired armed vessels, gun-boats, Revenue and excise cutters and packets, etc., corrected to June, 1795) we find the following:—

Physicians to His Majesty's Fleets.

Dr. Harness. Dr. Trotter.

Their pay £1 0s. 0d. per Day.

(in the same list is the name Horatio Nelson with the date 1778 as the year of his first commission as captain).

Trotter pursued his duties in a most indefatigable and zealous manner. When Physician to the Fleet, he used himself to "attend" the stalls at the vegetable markets, and scour the country round in order to obtain the supply of lemons he required for the sick.

He was evidently a keen observer, for he mentions that the issue of grog was followed by an increase in the amount of scurvy. Again, in discussing the prevention of contagious disorders, he says:—"Heat I consider as one of the most powerful correctors of contagion," what would he say could he but see our up-to-date sterilizers and disinfectors nowadays! Some of his passages are very quaint: he recommends a "band of music" in a ship as a preservative of health—and would "pronounce a physician strongly fettered in the craft of technicals, that excludes from his hygiene, the exciting influence of melodious notes, or the agile movements of the 'light fantastic toe.'" He mentions that he himself was passionately fond of both.

In the Navy List for May, 1797, among the list of surgeons is the name William Beatty (date of first warrant, 1796). This, I think, must be Nelson's surgeon; he evidently got on well, for in "A List of the Medical Officers of Her Majesty's Fleet," published in 1842, we find, among physicians retired, Sir William Beatty, Kt., M.D.

Sir Gilbert Blane, Bart., is probably the best known of all the old-time naval Medical Officers by reason of the "Gilbert Blane Medal," which is still presented periodically for meritorious professional services, and which also serves to perpetuate his name. Without a doubt, he was a very able and distinguished physician. In one of his works the following occurs:—"In the course of the year 1780, my first year of service as physician to the Fleet on the Windward Station, I found from my own returns and from examining the records of the hospitals, that the annual loss of lives from disease previous to our arrival, and for some time after, had been at the rate of one in seven"; and chief among the causes of this mortality from disease, Blane mentions "the abuse of spirituous liquors, and want of soap." He also says "it was not till the year 1795 that the general supply of lemon-juice was decided on by the Board of Admiralty" as a preventive, of course, for the scurvy; it was apparently first suggested by Dr. Blair, Chairman of the Board of Commissioners for the care of sick and wounded seamen.

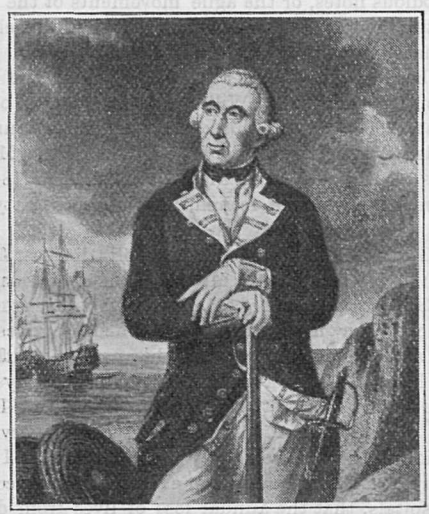
Naval surgeons are not always without honour even "in their own country," and when Mr. Anderson, one of Captain Cook's surgeons, died of "a consumption" at sea, on the same day, sighting land, that great commander, "to perpetuate the memory of the deceased, for whom he had a particular esteem, distinguished it by the name of Anderson's Island." Sir William Burnett is another famous name intimately connected with the Naval Medical Department, of which he eventually became Inspector-General — analogous to Director-General of the present time. Between the days when the department was supplied, and it may be said managed, by the Company of Barber-Surgeons, and our present system under a Director-General, things medical were for many years administered by a sort of Committee

styled the Commissioners of the Board for the care of Sick and Wounded Seamen—or the Sick and Hurt Office.

Robinson says that "on January 22nd, 1805, a uniform was first established for medical officers."

In 1812, the facings were ordered to be white; in 1825, "waistcoats and knee-breeches of white kerseymere were ordered for all grades, but pantaloons of white or blue cloth and half-boots were also allowed." "All civilian officers were to have black grips to their swords."

Physicians wore a dress rapier; the lappels of their coats were blue. Physicians' buttons had an anchor with a snake twisted around the shank and stock.



Admiral Kempenfelt.

In 1827 knee-breeches were abolished except at Drawing-rooms. In 1833 facings were changed from white to red, but later again back to white.

In 1843 all executives wore their buttons on their full-dress coats, double-breasted, and all civilians single-breasted, the doctors' buttons arranged in threes, and the sword-grips were changed to white. Later the buttons were changed in arrangement, and are now the same in all branches.

Various other peculiarities will be noticed in the accompanying illustrations, which require no further description here.

I have taken the above outline of changes in uniform chiefly from Commander Robinson's excellent book, "The British Fleet."

THE NAVAL MEDICAL SCHOOL.

Nowadays, naval surgeons enter the service by a competitive examination held twice a year in London for duly qualified men between the ages of 21 and 28.

The successful candidates, whose names are borne on the books of Nelson's old ship *Victory*, are immediately, or within a few days, sent to Haslar, there to undergo a four months' course of instruction in hygiene, the diseases of foreign stations, bacteriology, and naval surgery.

This course of instruction evidently was started—though not on quite the same lines—on 15th September, 1827, when a certain Dr. Scott "read an introductory lecture which was attended by twenty-two gentlemen belonging to the hospital and H.M. ships in the harbour and at Spithead. In this lecture I endeavoured to point out the nature and objects of the institution, and to pay a just tribute of respect to the late and present Lord Melville, to Dr. Burnett, Commissioner to the Victualling Board, etc., to the late Dr. John Harness, to our present Commissioner Dr. Weir, and the other Commissioners of the Board. I expressed the strong conviction I entertained that His Royal Highness, the Lord High Admiral, would nobly support the institution, following up the suggestion of Dr. Burnett, the founder, who had unremittingly laboured to establish the museum and library."

In the "Instructions for the Royal Naval Hospitals at Haslar and Plymouth" for 1834, one section is headed "Instruction for the Librarian and Lecturer." His duties were to give a course of lectures "twice a year in the practice of medicine and surgery, as far as may be more particularly applicable to the diseases which are prevalent among seamen, whether in the home or foreign stations," also occasional lectures in physiology, pathology, and pharmacology: he was also to keep a record of meterological observations, "for which purpose you will be provided with the proper philosophical instruments."

The audience was confined to "medical officers of the army and navy, whether on half-pay or otherwise," and other "respectable individuals" who were expected "to observe the strictest decorum and not presume to offer any remark on the opinions you may think proper to advance, either aloud or by whispering, such practice being calculated to distract the attention of the lecturer and the studious."

At a later period the instruction, then as now, more especially for newly-entered surgeons, was conducted at Netley by army officials.

On March 15th, 1880, an Admiralty Committee was appointed to consider, among other matters, "the question of examination necessary for candidates for admission to the service, and also in regard to the advantages or disadvantages of Netley Hospital for the use of the Naval Medical Profession."

As the result of the deliberations of this committee a medical school was established at Haslar, where newly-entered surgeons were instructed in ward duties, naval hygiene, pathology, metereology, etc., and also obtained a familiarity with the interior economy and ventilation of ships, and the more serious surgical and medical cases usually met with in naval medical practice. A laboratory was fitted up for their use, where the lower lunatic wards now are.

The first "Instructors" were Staff-Surgeon Walter Reid—widely known in the world of surgery for his method of treating aneurysms by rapid pressure—and Surgeon Collins.

The present laboratory was first used in 1899, in the latter part of which year the teaching course was much extended, the staff consisting of a Fleet-Surgeon, Staff-Surgeon, and Surgeon.

THE SICK BERTH STAFF.

The Sick Berth Staff consists of head ward masters (who are warrant officers), ward masters, sick berth stewards, first and second-class (petty officers), and sick bay men, or as they are more generally called, sick berth attendants.

The sick berth staff is only of recent formation, some twenty or thirty years old.

When Haslar was in its infancy, as Howard has shown, the nurses were women, and apparently, as was the case with other hospitals at the time, not always very refined sort of persons. Thus one of the old hospital regulations reads as follows, "That all nurses who disobey the matron's orders, get drunk, neglect their patients, quarrel or fight with any other nurses, or quarrel with the men, be immediately discharged the service of the house, and a note made against their names in the books of the hospital that they may never more be employed."

In ships the patients were nursed by seamen told off for the job, and in the "Regulations and Instructions relating to His Majesty's Service at Sea" for 1757, we read—"The captain is to appoint some of the ship's company to attend and serve the sick men night and day by turns, and to keep the place clean."

Apparently in those days there was no fixed sick bay (as it is called), for in the same regulations occurs this order—"Convenient room shall be made between decks in all His Majesty's ships for the reception of sick or hurt seamen, whither they are to be removed with their hammacoes and bedding, when the surgeon shall advise the same to be necessary."

Trotter, in 1803, says, "The apartments of the sick, before the present war, were very imperfect." The model that he recommended was that adopted by Captain Markham in the *Centaur*. "The Markham sick-berth takes in the two foremost guns under the fore-castle, and all that space from the ship's side to the foremast, so that it includes the mid-ships which was formerly occupied by a pig-stye."

Up to quite recently sick bay men were nick-named "lob-lolly-boys." The explanation of the term seems to be found in the following from an old book termed "Colloquia Maritima or Sea Dialogues," published in 1688. Salt provisions are mentioned as being the "one main cause, that our English are so subject to calentures (a shrensy or inflammation of the brain), scarbotes (scurvy), and the like contagious diseases," and the substitution of "husked hominy" and "lob-lolly" (made from maize) is recommended, although it was considerably doubted whether the seamen would appreciate the change. Even in those days the navy was apparently a very conservative institution; certain it is that now-a-days at all events, old customs and traditions die hard.

Under the present organisation, the sick berth staff was started in 1885, since when all "new entries" undergo a course of instruction in nursing, dispensing, cooking, and ambulance drill at Haslar, as probationers; at the close of the course an examination is held, and the successful candidates become full-blown attendants.

Previous to 1885 the uniform consisted of a cap without badge, a short blue Eton jacket with black buttons, black tie and blue trousers, now the cap has the badge of a crown and anchor, and the coat is a blue double-breasted monkey jacket, with gilt buttons and the Geneva badge on the right arm, the various badges distinctive of rank and good conduct are worn on the left sleeve.

It is the fashion among writers at the present time to say that men will never—or hardly ever—make good nurses. No more untrue or unjust statement was ever made. Among the naval sick berth staff the writer has met with numbers of men who could not possibly be bettered as attendants on the sick. A good attendant is respected throughout his ship, both by men and officers, and in many critical cases I have seen qualities displayed by these men, which were deserving of the highest admiration and praise, and in which they gained not only the confidence of the doctor, but the love and gratitude of the patient.

It would be invidious to mention names, although several occur to me at the time of writing, which would serve to illustrate the case.

Another comparatively recent institution has been the establishment of Naval Nursing Sisters. These ladies hold appointments in the Royal Naval Hospitals at Haslar, Plymouth, Chatham, and Malta. Before entering the service they require to have gone through a thorough training, and after their appointment, they take up their duties at one of the first three hospitals mentioned above, after which their names appear regularly in the Navy List.

THE LAST OF THE GREENWICH PENSIONERS.

The following yarn was spun to me by John Bright, aged 85, on 2nd October, 1901, in 53 ward, Haslar, of which he was an inmate. As he is the last *genuine* Greenwich pensioner I think it worth reproducing here.

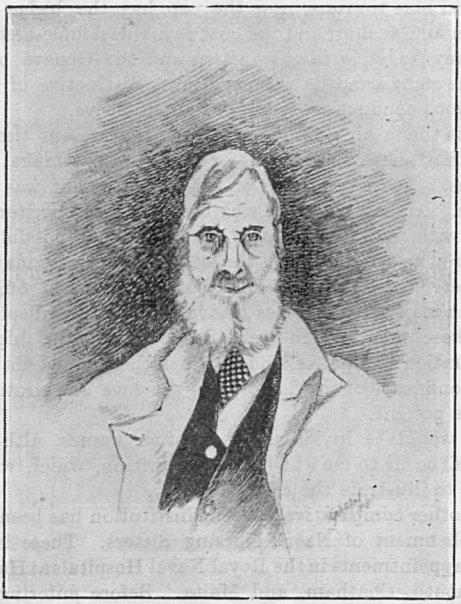
When Greenwich hospital, as a home for naval pensioners, was broken up in 1869, the old gentlemen were transferred to Haslar; they have gradually died off, and old Bright is the only one left who really ever was an inmate of the historic pile on the banks of the Thames.

I give the old gentleman's story as far as possible in his own words.

"Yes, *I am* a Greenwich pensioner, sir! Medals? yes, I did have some medals once, but I pawned 'em long

ago, for what's a man to do, sir? I got five shillings for the two Crimea medals, and a little time ago I thought I'd like to buy them back again, but they wanted seventeen-and-six—*seventeen-and-six-pence, sir!* for one only, so I never got them."

"In 1835 I joined the English legion, which was raised to fight for Queen Isabella II. of Spain, against Don Carlos—and I remained in Spain five years and seven months. In the same year I received two silver medals and a silver cross, in 1837 another silver cross, and in 1839 a gold medal, which carried with it the title of Don, the right to travel free all over the country, a



John Bright, the last Greenwich Pensioner, October, 1901.

pension of ten pence a day, and food, as long as I remained in the country; but later on I felt I wanted to return home. In 1841 I got a silver medal which was given to all the English troops who remained until the war was finished. In the same year I came back to England and worked on the new railway they were making between London and Gosport. However, this work gave me rheumatism in my hands from shovelling and wheeling barrows, so I joined the red marines then stationed in Portsmouth, and I remained in the corps fifteen years and one hundred and fifty days, and was then invalided for a bad knee. Whilst serving with the Marines I gained in 1855 the Crimea medal with two bars, and the silver medal given by the Turks. After being invalided in 1856, I joined the *Sidon*—the 'lop-sided *Sidon*' we used to call her—as 'lob-lolly-boy' (sick bay man). In those days they were rated as A.B.'s, and had six-pence a day extra pay; but one day hurrying to get something for the doctor from the cockpit, and not knowing they'd taken the ladder away, I fell down a hatchway and dislodged my liver, so had to be invalided home. When I was better I served in the *Illustrious* as an A.B., and then in the *Marlborough*. When I was in the latter ship I fell overboard, was taken ill, and eventually invalided out of the service at Haslar. Then I went to Greenwich hospital as a pensioner, but in 1865 I went out to Australia, where I was offered a good job at £2 5s. a week, and I didn't return to England until 1882. While I was away Greenwich hospital was done away with.

"When I came home I lived with my son for a while, then I left, and after being in the union a short time, I came into the Haslar hospital."

It is interesting in connection with this story, to recall what terrible sufferings the British Legion underwent in Spain; the natives hated them as foreigners, the generals in many cases were not too capable, typhus and dysentery both raged with violence, and the battles were desperate. Truly old Bright has lived his life.

THE OLD CEMETERY.

One day, towards the latter end of September, 1901, I was introduced to Mrs. B———. Mrs. B——— had often heard her great-uncle, the late Captain Young, R.N., formerly of No. 1, High Street, Portsmouth, talk of the wreck of the *Royal George*, in 1782, of which disaster he was an eye-witness.

He was walking along the sea-front, which now extends along the front of the new Zymotic Hospital, and saw the great line-of-battle ship lying out at Spithead, surrounded by a number of small shore-boats which had brought off visitors, friends and relations, to bid farewell to the officers and crew.

He turned for a moment to look at some object inland, and when again he directed his gaze seaward the mighty ship had gone; hardly a vestige of her was to be seen. In an instant the noble ship had capsized and sunk, carrying with her Admiral Kempenfelt and some 600 or 800 men, with many women and other shore-going friends. It seems that the *Royal George* was being careened over to port to have her bilges cleaned, when, either caught by a breeze or for some other reason—and her ports being opened—she suddenly heeled over too far, filled and sank.

For days afterwards bodies were washed up—not only on to the mainland, but also on the beech near Ryde, in the Isle of Wight. It is not known where Kempenfelt was buried; quite possibly at Haslar, although no record can be found. Certain it is that many burials have taken place in various parts of the hospital grounds which are no longer used for such purposes, and of which absolutely all knowledge is now lost.

The house in which this small history is now being written stands on part of what was once a graveyard. It is said that some long time past Haslar was the scene

of a great battle, which accounts for some of the numerous skeletons found, but whether this is true or not I do not know. Numerous skulls and bones have been dug up in the course of building operations in parts of the grounds which were never previously supposed to have been consecrated.

There is one tomb-stone which still remains in a corner of this supposed unconsecrated ground, and the fact that the ground was supposed to be unconsecrated, and that the inscription had become undecipherable except by an expert, led to the belief that the grave must be that of a suicide; and popular legend—amongst the few who ever took any interest in the matter—had it that the monument was in memory of the young and lovely daughter of a long-time-past Captain-Superintendent, who, disappointed in love, sought relief from her misery in self-inflicted death.

Unfortunately this legend, which might have given some sentimental—or sensational, which you will—

View in the Old Cemetery, Haslar.

interest to Haslar, was upset by a recent Inspector-General, who had the unkind curiosity to obtain an expert's opinion on the inscription: it turns out to be only the grave of a deceased naval chaplain, and his brother, a colonel in a line regiment, which was stationed at Gosport at the time of his death.

Truth may be stranger than fiction, but sometimes at all events it isn't half so picturesque.

The other skeletons found may have belonged to victims of the *Royal George* disaster, or to French Prisoners who died at Porchester Castle and elsewhere, or to Portuguese patients who died in Haslar.

Until the new cemetery was opened a short time back in Clayhall, there used to be a small Turkish grave yard where part of the Zymotic Hospital now stands; this, however, was transferred bodily when the ground was wanted. The old cemetery at Haslar is a most picturesque spot. It was consecrated in 1827, although some of the tomb-stones are dated back to 1800 or earlier. Thus there is one "To the memory of Mr. Edward Young, Surgeon of His Majestie's Royal Hospital at Haslar, who departed this life Dec., 18th, 17——, aged 64 years, and was buried in this ground by his own Desire." Truly, promotion was slow in those days! Again, "To the memory of Nicholas Easters, late Master's Mate of His Majesty's ship M . . . . Haslar Hospital of Fever . . . . on board the above ship . . . . French Prisoners . . . . Earl Howe's Glorious Victory on the 1st of June 179—, aged 25 years."

Much of these inscriptions is now worn away and illegible.

Beyond the residents of Haslar, the policemen on duty, the gardeners, and three white owls, the sanctity of this really beautiful spot has few invaders.

The new cemetery is situated outside the hospital grounds, so calls for no further remark here. The old cemetery is now disused.

Appendix I.—The present staff at Haslar consists of—

1 Inspector-General.
2 Deputy Inspector-Generals.
1 Chaplain.
2 Fleet Surgeons.
1 Staff Surgeon.
1 Store Officer.
1 Inspector-General's Secretary.
1 Head Dispenser.
5 Surgeons (2 more have been added since writing this).
1 Civil Engineer.
3 Assistant Dispensers.

Besides Nursing Sisters, Head Ward-Master, and minor officials.

Appendix II.—Until November, 1869, the appointment of Dispenser at Haslar was held by a medical officer—a Staff Surgeon—and the Assistant Dispensers were unqualified. Then things were changed, and the dispensing and dispensing stores put in charge of a Head Dispenser, who was assisted by a staff of properly-qualified Assistant Dispensers; this system is still in force.

Appendix III.—Fleet-Surgeon G. Kirker, R.N., was kind enough to lend me an interesting pamphlet from which I venture to give the following abstract:—

Before the large naval hospitals were established it seems that naval medical charges were thrown as much as possible on the "Chest of Chatham." This was an early benefit society established in 1588, supported by the mariners themselves for the relief and support of the hurt and maimed.

The chest itself was kept in the south porch of Chatham Parish Church, and later at Greenwich Hospital.

The pensions awarded varied from £12 a year for the loss of both eyes to £4 a year for the loss of one eye, or for compound fracture, or for ulcerated legs, or fractured skull, etc.

The Chest Fund apparently flourished, and in 1814 was amalgamated to the tune of £1,355,400, together with its estate, with the funds of Greenwich Hospital.

APPENDIX IV.—Besides to Dr. Kirker, I must own my indebtedness to the Rev. C. R. Mullins, R.N., and Mr. W. H. Long, of Portsmouth, for helpful suggestions to Mr. Arthur Walford's "Historic Sketches of Gosport," and finally to Mr. Wilks, of Haslar, who did the photographic work for me at a very much reduced charge.

GERALD SICHEL,
(Late R.N.)

Novelties.

"TRISCUIT" IN THE WARDS.

Nowadays there is little real difficulty in selecting a proteid food, or a specially digested carbohydrate preparation which shall suit the most irritable or capricious stomach. Generally, it must be admitted, these preparations appeal more to the physician than the patient, and it is only a firm conviction that they "will do him good" that leads to their steady consumption.

In the case of the large class of convalescents, who cannot safely be allowed more than a farinaceous diet, it is a matter of common experience that tasty and attractive cereal foods are of great advantage to the practitioner in allowing him to relieve the monotony of the prescribed diet and at the same time encourage the patient to increase his intake. Triscuit has been tried in the wards in such cases and has been found very valuable. The subjective sensations from eating Triscuit are similar to those produced by a meal of porridge, with the exception that the great bulk of the Scotch meal is avoided. The food is equally pleasant, not so "filling," and uniform throughout. That is to say, there is never a hard indigestible lump nor a tough gelatinous mass. Soaked in boiling milk, which may previously be sweetened, Triscuit forms an admirable breakfast dish, or light supper, and from its ready preparation will be found most useful in the nurses' armament of sick foods.

Sport.

Guy's Hospital Lawn Tennis Club.

On Wednesday, July 8th, we beat Gravesend by 6 to 2, on the Bat and Ball Ground, at Gravesend.

F. Palmer and Zorab beat Bridgland and Sandford, 3–6, 6–4, 7–5; beat Richards and Clay, 6–0, 6–1; beat Apps and Styles, 6–1, 6–0. Earle and A. Palmer beat Richards and Clay, 6–3, 6–1, beat Bridgland and Sandford, 4–6, 6–4, 6–1; lost to Apps and Styles, 4–6, 2–6. W. G. Pinching and Turner lost to Apps and Styles, 4–6, 2–6; beat Richards and Clay, 6–3, 6–4.

On Saturday, July 11th, Harold beat us at West Norwood by 5 to 2.

Lucas and Wedd beat Bates and Eccles; beat Hanson and Green. Earle and Zorab lost to Bates and Eccles, lost to Hanson and Green; drew with Ransford and Bright. Scales and Turner lost to all three pairs.

The Inter-Hospital Lawn Tennis Cup was won by St. George's who beat London in the final.

T. C. Lucas played for the United Hospitals against Cambridge, on Friday, June 12th. F. W. M. Palmer was also chosen but was unable to play.

On Wednesday, July 22nd, we beat Sidcup at Honor Oak Park by 6 events to 2.

Lucas and Palmer beat Beater and Solomon, 0–6, 6–3, 6–4; beat Young and Thompson, 6–0, 7–5; lost to Caine and Beale, 1–6, 1–6. Zorab and Earle beat Caine and Beale, 6–1, 6–3; lost to Beater and Solomon, 3–6, 3–6; beat Young and Thompson, 6–3, 6–1. Wedd and A. Palmer beat Young and Thompson, 6–3, 6–3; lost to Caine and Beale, 6–4, 3–6, 1–6; lost to Beater and Solomon, 1–6, 1–6.

On Saturday, July 25th, we lost to Kent by 2 events to 6.

Palmer and Zorab lost to Hook and Murray, 1–6, 6–4, 7–9; beat Heelas and Cousins, 6–5, 6–4; beat R. Heelas and Wilson, 6–1, 4–6, 6–1. Winckworth and Earle lost to Heelas and Cousins, 6–4, 2–6, 9–11; lost to Hook and Murray, 6–4, 4–6, 1–6. Bates and A. Palmer lost to Heelas and Cousins, 2–6, 3–6; lost to R. Heelas and Wilson, 0–6, 3–6; lost to Hook and Murray, 2–6, 3–6.

Appointment.

HANDLEY, W. S., M.S. Lond., F.R.C.S., has been appointed Richard Hollins Cancer Research Scholar at Middlesex Hospital.

Births.

MAYSTON.—On July 28th, at 58, Pier Road, Erith, the wife of Robert W. Mayston, M.D. Lond., M.R.C.S., L.R.C.P. Lond., of a daughter.

PEDLEY.—On July 8th, at Peckham Road, Camberwell, to Ada Elizabeth and S. Edward Pedley, M.R.C.S., L.R.C.P. Lond., a son.

Death.

STARLING.—July 11th, at Bombay, very suddenly, M. H. Starling, Esq., B.A., LL.D., Clerk of the Crown and Barrister-at-Law, in his 66th year.

ED.—J. M. B.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, SECRETARY'S OFFICE, GUY'S HOSPITAL.

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING AND SIXPENCE.

Calendar of Coming Events.

August, 1903.

Sat. 29.—Messrs. Golding-Bird and Dunn's take-in; Drs., L. Myer and G. Russell; Cl., L. S. H. Glanville.

September.

Tues. 1.—October Appointment List closed.

Thur. 3.—Messrs. Jacobson and Fripp's take-in; Drs., A. F. Hertz and C. M. Stevenson; Cl., K. Black.

Sat. 5.—October Dental Appointment List closed.

Mon. 7.—Revision Classes for L.D.S. Eng. begin.

Thur. 10.—Messrs. Symonds and Steward's take-in; Drs., W. M. Mollison and W. Reeve; Cl., A. R. Brailey.

Guy's Hospital Gazette.

AUGUST 29, 1903.

A Case of Chronic Intestinal Obstruction associated with an Aneurysm of the Abdominal Aorta.

CLINICAL LECTURE BY DR. J. H. BRYANT.
July 1st, 1903.

GENTLEMEN,—It is customary when in charge of Clinical to select a case or series of cases from these wards as a subject for a clinical lecture, but, as this lecture happens to fall on the first day of my six weeks tenure of office, and I have not yet seen any of the patients who are under my care, I have chosen the following interesting case, which was sent to me last January by Dr. Wallis, as the subject for discussion this afternoon. I have been influenced in this selection for two reasons: firstly, as a correct diagnosis was not arrived at until the time of the post-mortem examination, and cases of difficult or mistaken diagnosis are always instructive and have their lessons to teach; secondly, as it will give me an opportunity to talk to you about a very rare disease which is frequently mistaken for a somewhat common and much less serious condition.

I shall first of all read an abstract of the medical history of the patient and of her condition on admission from the report of Mr. F. M. Longson, and discuss the diagnosis; I shall then describe the result of the operation by Mr. Dunn, next relate to you the termination of the case and the result of the post-mortem examination, and lastly shall describe the disease from which she suffered based on an analysis of fifty-four cases from our post-mortem records.

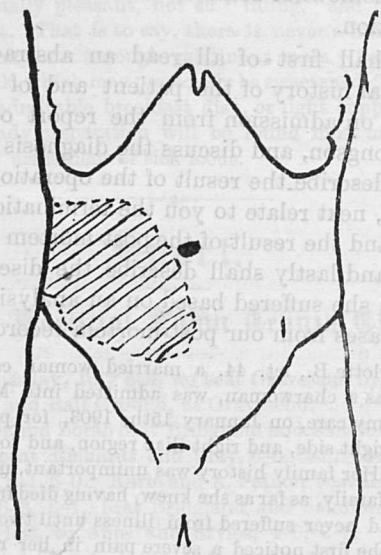
Charlotte B., æt. 44, a married woman earning her living as a charwoman, was admitted into Mary ward, under my care, on January 15th, 1903, for pain in the back, right side, and right iliac region, and for constipation. Her family history was unimportant, no members of her family, as far as she knew, having died from cancer. She had never suffered from illness until two years ago, when she first noticed a severe pain in her right sacro-iliac region which extended to the right side, and after

lasting a few days passed off. She has had numerous attacks since at intervals varying from a week to a month or two, which are always associated with constipation, which usually lasts for three or four days. Between the attacks her bowels are regular. In November last she brought up a lot of blood and blood clots and fainted, but felt considerably better afterwards. She has been married for twenty years to a phthisical husband, and has had seven children, all of whom have died young, six at about six weeks of "weak chests," and one at six from diphtheria.

On January 10th she had a severe attack of pain which extended to the right iliac region, and it was so bad that she was obliged to go to bed. She had been completely constipated since the 10th, and had passed neither fæces nor flatus. On Monday, January 12th, she was sick, but had not been so since. She stated that she had lost flesh during the last two years.

Condition on admission.—Temperature 98·4°, pulse 76, respiration 22. She was thin, anæmic, sallow, and cachectic looking. Her face was drawn and pinched, and she wore an expression of pain. She laid in bed on her back and did not move more than she was obliged as it gave her pain. Her breath was very foul and offensive. The tongue was moist and covered with white fur, except at the edges. There was no blue line on the gums.

The abdominal wall was very thin and flaccid, and the surface was irregular owing to the presence of distended coils of intestine pushing it forwards. It moved well on respiration. Peristaltic movements were visible in these distended coils of gut. The right rectus abdominis and extensor oblique muscles were contracted, rigid, and constantly twitching. There was marked tenderness over the right iliac region, *vide* diagram—the abdominal wall was very rigid.



Occasionally an indefinite sort of tumour could be felt below and to the right of the umbilicus, and this part of the abdomen was always very tender.

No abnormal pulsation in the abdomen was detected.

Digital examinations of the rectum and vagina were made, but with negative results. There was neither tenderness nor undue prominence of the spines of the lower vertebræ. The heart and lungs appeared to be normal. The knee jerks were present and the pupils reacted to light and to accommodation. There were no external manifestations of syphilis.

That was how the case presented itself to us.

The diagnosis, of course, was the first problem to solve, and I shall attempt to review and discuss the history, symptoms, and physical signs, as we did at the bedside.

To briefly summarise the case :—The patient was a middle-aged married woman who had borne seven children, all of whom had died young. She complained of pain in the lower part of the right side of the back and abdomen and of constipation, attacks of which she had been subject to off and on for two years. The attack for which she was admitted had lasted five days. On admission the abdomen was distended, the outlines of coils of distended intestine with visible peristaltic movements were seen and the lower two-thirds of the right side of the abdominal wall was tender and rigid, and an indefinite tumour could be felt at times. The temperature was 98·4°, the pulse rate 76, and the respirations 22.

We first came to the conclusion that she was suffering from some form of chronic intestinal obstruction, the complete constipation, the non-passage of flatus, the distended coils of intestine showing visible peristaltic movements pointing to this view.

The next consideration was to discover, if possible, the cause of this condition.

The following are some of the most important causes of chronic intestinal obstruction :—

a. Impacted fæces.

b. Intestinal concretions.

c. Lead poisoning.

d. Malignant stricture of the rectum, colon or cæcum.

e. Syphilitic stricture of the rectum.

f. Chronic intussusception.

g. Tumours, enlargements and displacements of viscera, especially in the pelvis, pressing on the gut.

h. Contraction or kinking of the intestine.

Impacted fæces.—Chronic obstruction from this cause usually occurs in women and follows prolonged constipation. In this patient the attacks of constipation were intermittent, did not alternate with diarrhœa and were associated with concurrent attacks of severe pain. As a rule, in the early stages there is no pain, and even in the later periods when obstruction is well marked and there is nausea and vomiting, pain is very rarely acute. The very definite and severe pain on the right side of the abdomen was therefore a strong point against the diagnosis of simple fæcal impaction. The usual seat of obstruction is the sigmoid and rectum. In this case there was no appreciable collection of fæces in either of these portions of the gut. It was thought that the indefinite tumour which was felt in the right iliac region might be due to the presence of fæces in the cæcum but it did not present the characteristic soft, doughy, feeling associated with tumours of this nature.

Intestinal concretions.—Hair, skin or seeds of fruit, husks of cereals, magnesia, chalk, etc., may collect in the large intestine, usually in the cæcum or rectum, form large hard masses, and give rise to signs of chronic intestinal obstruction. They are found most frequently in patients of weak intellect or unsound mind. In the case under discussion there was no history or evidence of any unusual diet or method of living, and the digital examination of the rectum did not reveal the presence of any large hard mass.

I have reported (*Clinical Journal*, June 12th, 1901, p. 114) a case of this nature, and as it is of unusual interest I take this opportunity of referring to it again :—

The patient was a boy, æt. 11, who was admitted under the care of Dr. Goodhart on December 15th, 1891, when I was Dr. Goodhart's house-physician. His bowels had been opened without any difficulty on December 10th. On the following evening he attempted to pass a motion but failed to do so. Unsuccessful attempts followed on the 12th, 14th, and 15th, and were accompanied by a good deal of pain in the rectum. It was found, on making enquiries, that on December 9th he went for a walk near the docks, and was present when a cart laden with cinnamon bark was upset. He filled his pockets with bark and ate a considerable amount of it. On admission he was suffering from a good deal of pain in the rectum and lower part of the abdomen. His tongue was furred and his breath was very foul. A rectal examination revealed the presence of a large hard mass which felt like an enterolith. Enemata being of no avail an anæsthetic was administered, and by means of a spoon a large, hard, solid mortar-like mass, consisting almost entirely of small chips of cinnamon bark was removed. On the 18th he passed a normal motion, and on the 21st was discharged quite well.

Lead poisoning.—The possibility of this condition was considered and investigated, but there was no blue line on the gums and there was no evidence forthcoming of contact with lead in any form. Some women show a peculiar susceptibility to the influence of lead. I remember two cases which illustrate this point. One woman was admitted for abdominal pain and constipation, and she had a well marked blue line on the gums. She was the wife of a master painter, and the only occasion on which she came within reach of lead was when she walked through the shop. She stated that she did not brush her husband's clothes.

The other woman was admitted as a case of chronic intestinal obstruction from carcinoma, with a view to immediate colotomy. She had been completely constipated for several days, had vomited and was complaining of severe abdominal pain. On examination, however, her abdomen was not distended and the pain was relieved by pressure. The clue to a correct diagnosis was a blue line on the gums, and it is a good rule in all cases presenting similar symptoms to carefully examine the mouth. It was found that she lived next door to a lead factory but had never worked in it. She subsequently died in a comatose condition after having had a number of severe epileptiform convulsions.

Malignant stricture.—Carcinoma most frequently attacks the sigmoid, rectum, or descending colon, and more rarely the cæcum or ascending colon. Nausea and constipation alternating with the evacuation of loose motions, are the commonest early symptoms. Later on the constipation becomes more troublesome, fœtid eructations are frequent, and are followed by vomiting, which in the final stages may become fæcal. The abdomen becomes distended, the outlines of distended coils of intestine showing marked peristaltic movements become visible, and pain of a paroxysmal character, which varies very much in severity, is complained of. Emaciation and cachexia in the majority of cases become well marked.

In this patient nothing abnormal was felt per rectum, and there was no tumour in the left iliac region. The constipation, the paroxysmal pain, the indefinite tumour in the right iliac region in a woman of this age made us seriously take into consideration the possibility of malignant disease of the cæcum or commencement of the ascending colon. The duration of symptoms, however, for two years, was against this diagnosis.

Syphilitic stricture.—This form of obstruction involves the rectum and follows syphilitic ulceration. A digital examination shows a good deal of thickening and contraction of the parts, and if an examination is made by means of a speculum, a large amount of cicatricial tissue may be seen. There was no definite history or evidence of syphilis in this case, and further, the rectum appeared to be normal.

Chronic intussusception.—This form of intestinal obstruction is the most difficult to diagnose correctly as the symptoms are frequently very ambiguous and confusing. It may last for several months and even for a year. The condition of the bowels is very variable; constipation or diarrhœa or constipation alternating with diarrhœa may be present, and blood is found in the motions in about 50 per cent. of the cases. Pain is an early symptom and is generally severe and paroxysmal in character, occurring as a rule several times in the day, but in some cases the attacks are very irregular coming on at intervals of several days or even weeks. Vomiting is not a constant symptom but attacks are usually associated with the occurrence of pain. An abdominal tumour can be felt in 50 per cent. of the cases and in about 30 per cent. the end of the invaginated portion can be felt per rectum. On account of the indefinite tumour which was felt in the right iliac region, which is the position in which the tumour of chronic intussusception is frequently felt, this disease was seriously considered as a possibility, but it was thought that the long duration of the symptoms and the history of no blood having ever been passed from the bowel, were the most important points against this diagnosis.

Tumours, etc., pressing upon the gut.—Chronic obstruction from this cause is most frequently due to pelvic tumours pressing on the rectum. The absence of any sign of such a condition on making a digital examination of the rectum and

vagina, was the chief evidence against this view. The possibility of the tumour which was felt in the right side of the abdomen being an aneurysm of the abdominal aorta was never discussed, for there was no pulsation and no definite evidence of syphilis or of very hard work.

Contraction or kinking of the gut.—This form of obstruction may follow local peritonitis or be caused by contraction of the mesentery as a result of tuberculous or malignant disease. It is by far the commonest cause of chronic obstruction of the small intestine. Irregular attacks of vomiting and constipation, colicky pain and visible peristalsis are the chief symptoms. There may be a history of old peritonitis.

The recurring pain in the right side of the abdomen, which was always associated with constipation, was strongly suggestive of attacks of appendicitis. The normal temperature and pulse rate on admission, however, we considered, to contra-indicate another acute attack of this disease; so we came to the conclusion that there was in all probability some contraction and kinking of the gut which had been brought about by attacks of local peritonitis in the appendix vermiformis. The alternate diagnoses were:—Malignant stricture of the ascending colon or impacted fæces. The question of treatment was next discussed, and it was decided to administer an enema, so a soap enema was given, but no action of the bowels followed. A castor-oil enema was then administered, but with a similar result. I then asked my colleague, Mr. Dunn, to see her with me: he agreed on the diagnosis of chronic obstruction, but as the general condition and the pulse and temperature were so satisfactory, it was decided to defer the question of operation. Another soap and castor-oil enema was ordered, and the following pill to be taken every four hours—

℞ Hyd. cum. Cret. ...	...	gr. ii.
Ext. Bellad. Alch.	...	gr. $\frac{1}{6}$.
Pulv. Ipecac. Co.	...	gr. i.
Glucos. Liq. ...	ad	gr. iv.
		4 t. horis.

January 16th. Her condition was unchanged with the exception that the abdomen was a little more distended.

January 17th. There was no further change, but as her bowels had not been opened, Mr. Dunn again saw her and decided to operate on the following day.

January 18th. A.C.E. was administered. Mr. Dunn then made a vertical incision about four inches in length midway between the umbilicus and the right superior iliac spine and opened the peritoneal cavity. Through the opening the whole of the large intestine was examined and the greater portion of the small intestine, when it was found that nearly the whole of the lower part of the ilium and the greater part of the colon were filled with scybala. No definite lesion could be found to account for this condition; the appendix was perfectly healthy, and it appeared at this time as if the peritoneal cavity had been opened for impacted fæces. A very peculiar appearance of the mesentery was noticed, consisting of numerous white patches and streaks connected with the mesenteric glands, which were thought to be due to presence of chyle in the lymphatics, which were much distended.

As a result of the information obtained by the operation it was decided to administer one grain doses of calomel every hour until the bowels commenced to act.

I confess that the result of the operation came as a great surprise to Mr. Dunn and myself, for we fully expected to find some definite cause in the right iliac region to account for the chronic obstruction.

January 19th. The bowels acted frequently after the operation and she felt much relieved. She complained, however, of a difficulty in passing her urine.

January 20th. Her general condition was better, but it was necessary to pass a catheter to relieve the retention of urine.

January 21st and 22nd. She was no longer troubled with retention, and felt much better.

January 23rd. She felt rather weak and complained of a dull aching pain over the seat of the operation. At 7 p.m. she suddenly became very collapsed, complained of some pain in the abdomen and right leg, and soon lost power in that limb. I saw her about 9 p.m. and found her anæmic, restless, and complaining of pain in the right side of her abdomen, which felt very hard and resistant. Her pulse was 120, and very soft and running in character.

It was evident that she was suffering from a sudden and considerable loss of blood, and the possibility of the rupture of an abdominal aneurysm into the retro-peritoneal tissues was discussed for the first time. She was infused with saline solution and for a time rallied, but gradually sank, and died at 1.30 a.m.

The post-mortem examination was made by Dr. Fawcett. On opening the abdomen a large quantity of blood was found extravasated beneath the peritoneum, chiefly on the right side, which extended into the loin, displaced the right kidney forwards and passed downwards into the pelvis as far as Poupart's ligament and outwards to the iliac crest.

Immediately below the diaphragm was an aneurysm the size of an orange, the orifice leading into the sac being circular and about the same diameter as a florin. The sac was firmly attached to the vertebræ, from which it had to be cut away. The bodies of the twelfth dorsal and the first and second lumbar vertebræ were extensively eroded, the cartilages being intact. A rupture had occurred at the lower right hand corner of the sac and so accounted for the distribution of the blood over the above mentioned area.

Some atheromatous patches were found scattered through the aorta, but the changes were not very marked. There were no definite external manifestations of syphilis.

The result of the post-mortem examination gave us food for reflection, and the thought naturally arose:—Was there sufficient justification, or was it possible to have made a correct diagnosis during life? It is a difficult disease to diagnose, for, an analysis of fifty-four cases which have occurred at Guy's Hospital shows that a correct diagnosis was only made in eighteen, *i.e.*, one third of the cases.

What are the characteristic signs and symptoms of an aneurysm of the abdominal aorta?

The presence of an abdominal tumour with distinct expansile not transmitted pulsation, a systolic bruit over the tumour, severe pain in the back, and symptoms arising from pressure on adjacent parts in a patient who has suffered from syphilis, and has been engaged in a laborious occupation, or has had an injury to the back.

With the exception of the severe pain in the back, which was due to an erosion of the vertebræ, which is certainly an early and characteristic, but by no means pathognomonic symptom, there were no other signs of aneurysm, no definite tumour, no expansile pulsation, no evidence of syphilis; and on the strength of this incomplete evidence it would have been extremely rash to have diagnosed aneurysm; in fact, the diagnosis of this disease must never be made lightly on account of its extreme rarity, and this applies in particular should the question arise in a woman.

I have recently had occasion to analyse the records of the post-mortem examinations performed at this hospital, from the point of view of diseases of the abdominal blood-vessels, and can, therefore, give you some figures to illustrate the great rarity of this disease. During a period of forty-seven years, from 1854 to 1900 inclusive, there are reports on 18,678 necropsies, and of these 325 were cases of aneurysm of the aorta, of which only fifty-four were of the abdominal portion.

A further analysis of these cases is of great interest, as it shows how much more frequently males are affected than females, for of the fifty-four cases, forty-nine were men, so that only five females have died from this trouble out of nearly 19,000 cases.

One of these female cases was a girl, æt. 12, who was admitted into Miriam ward under Dr. Pitt, in November, 1895, for œdema of the face and limbs, anæmia and pyrexia. She gave a history of two attacks of chorea, one in 1893, and the other in April and May, 1895.

On admission.—There was a musical apical systolic murmur, the urine contained blood and albumen, and the spleen was felt below the costal margin. A diagnosis of ulcerative endocarditis and glomerular nephritis was made. She died suddenly on November 7th.

Post-mortem examination. — There was an embolus fixed to the anterior wall of the aorta and its bifurcation and an aneurysm was commencing to form as a result of softening of its coats. The mitral valve was covered with large fungating vegetations. The kidney weighed 13

ounces and presented the usual "flea-bitten" appearance on the surface and on section, which is typical of infective endocarditis.

If this case is excluded it leaves only four cases of aneurysm of the abdominal aorta in women out of nearly 19,000 necropsies spread over a period of forty-seven years.

I therefore repeat, that the diagnosis of this disease in a woman must not be made lightly. A diagnostician must be bold and devoid of any post-mortem experience to conclude that a woman is suffering from aneurysm of the abdominal aorta unless he has any definite evidence of such a condition in the form of a tumour with expansile pulsation and severe pain. The mistake is frequently made in cases of pulsating abdominal aorta, a condition I shall describe in my next lecture.

Although none of the fifty-four cases were mistaken for chronic intestinal obstruction, constipation was a noticeable feature in sixteen, *e.g.*, nearly 30 per cent., but it was not, in any instance, so intractable to treatment as in the case under consideration.

With regard to the cause of the constipation, it did not appear to be due to direct pressure on any part of the intestine, but it seemed to be quite clear that it was associated with the pain caused by the presence of the aneurysm, for, she definitely stated that in the intervals between the attacks of pain from which she had suffered the action of her bowels was quite regular.

The condition which puzzled us most during life, was the twitching of the right rectus muscle, which suggested the possibility of nerve irritation, and, conjoined with the pain in the back, it perhaps should have made us consider the possibility of an aneurysm. We came to the final conclusion, however, that if the condition could not be diagnosed when the peritoneal cavity was opened and explored with the hand, that it was impossible to do so by means of an ordinary physical examination.

A Note on the Pathology of Acute Rheumatism.

By E. W. AINLEY WALKER, M.D.
Gordon Lecturer.

That acute rheumatism is an infective condition will hardly be doubted at the present time, and that the infection is of a specific character is highly probable from the clinical aspect. Practically all clinicians who have made a special study of the disease are agreed upon the question of its specificity.

On the pathological side a mass of evidence has been gradually accumulating in the past six years, which leads to the conclusion that a particular micro-organism is constantly associated with rheumatic fever, and can be isolated from acute rheumatic lesions. (Triboulet, Wassermann, Paine and Poynton, Meyer, Beaton and Ainley Walker). This micro-organism can be cultivated through excessive generations in the laboratory, and upon suitable injection into animals has occasioned pyrexia, aneurysm, acute mono- or poly-arthritis, endocarditis, pericarditis, myocarditis, iritis, &c. These lesions tend to recover completely, and the acute poly-arthritis may be repeated in a series of successive infections. Severe infection tends to terminate in a fungating endocarditis, frequently associated with visceral infarctions. (Paine and Poynton, Wassermann, Beaton and Ainley Walker, Herman Shand).

The organism concerned has been described as a diplococcus, a streptococcus, and a streptodiplococcus, by different observers. The microscopical arrangement depends, however, to a very great extent upon the character and composition of the culture medium employed. And Beaton and I were unable to discover either microscopically or in the ordinary culture media any distinctive differences between this organism and any other streptococcal form. It followed that

in ordinary routine examination the micro-organism would be reported as an ordinary streptococcus, and consequently that the use of the term diplococcus in rheumatism was likely to delay the general recognition of this organism. Since, however, we had by special methods found some points of difference between the micro-organism and ordinary streptococci, we ventured to distinguish it from these by a general term more in accordance with the requirements of systematic bacteriology in speaking of it as the micrococcus rheumaticus.

The differences in question have already been reported, they consist in--

1. The alteration of the blood pigment in a blood-agar culture of the micrococcus, leading to a colour change from red to brown, and later on from brown to brownish yellow—similar to the change produced by the pneumococcus (Eyre and Washbourn) and by the bacillus influenzæ of Eyre. This change is not produced by ordinary streptococci.

2. The faculty of growing in filtered cultures of an ordinary streptococcus is a faculty which Marmarck showed is not possessed by any of the ordinary streptococci.

3. The property of growing best in highly alkaline media.

4. The rapid production in such media of considerable quantities of acid.

Those differences sufficed for a provisional separation of the rheumatic micrococcus from the ordinary streptococci, and they are quite as definite as those by which some other micro-organisms are distinguished from each other. Whether they amount to a *specific* difference is perhaps an open question.

In the attempt to obtain some further evidence on this problem, attention was directed to the chemistry of rheumatism, and in the first case to the acid production which is so marked a feature both of rheumatic fever and of the laboratory cultivation of the micrococcus.

I was fortunate enough to interest Mr. Ryffel in the subject, and we have now been working on it for some sixteen months. About a year ago we were able to state that the acid in question is not lactic acid which has figured largely in the theories of rheumatism, and we are now in a position to lay down the following propositions :—

1. The micrococcus rheumaticus produces *formic acid* in very considerable quantity, and also at least one other acid of the fatty acid series.

2. Formic acid is present not only in the filtered cultures, but also in the bodies of the micrococci themselves. The washed micro-organisms contain also at least one of the higher fatty acids.

3. Ordinary streptococci only give rise, so far as we have yet been able to determine, to a small quantity of formic acid in similar media. This observation promises to constitute a further distinction between the micrococcus rheumaticus and other members of the streptococcus group.

4. In acute rheumatism formic acid appears in the urine in most appreciable quantities. In normal urine it is only present in minute amounts.

5. Under the salicylic acid treatment of rheumatic fever, the amount of formic acid in the patient's urine is diminished.

We are, of course, pursuing the whole subject further, but these results appear to be sufficiently suggestive to deserve recording.

Papers by Guy's Men.

On the Treatment of Summer Diarrhœa in Infants. By H. T. Hicks, F.R.C.S. Eng. —*Lancet*, 15th August.

A Note on Colotomy and Colectomy. By F. T. Paul, F.R.C.S. Eng.—*Ibid.*, 8th August.

Three Cases of Excision of the Cæcum. By F. T. Paul, F.R.C.S. Eng.—*British Medical Journal*, 15th August.

Dislocation of the Ulna and Radius at the Elbow, outwards and forwards without Fracture.

An engine-room artificer fell a distance of about ten feet in the engine room, pitching on to his left elbow. When seen, almost immediately afterwards, the forearm was fully supinated, flexed at a right angle to the arm, and almost immovable as regards flexion and extension, though the pronation and supination could be obtained with comparative ease and freedom from pain. The internal condyle was extremely prominent, with the skin stretched over it to such a degree of tension that it appeared to be almost at bursting point. There was a large prominent mass on the outer side of the elbow, and on the outer side of this, and well in front of the lower end of the humerus, the head of the radius was easily recognisable, both by its shape and its movement on rotating the wrist. The external condyle could not be felt, owing to the tenseness of the skin and the triceps tendon behind, and the mass of muscle in front. The posterior surface of the humerus could be followed down to the olecranon fossa, which was quite empty. The olecranon process could be distinguished lying against the outer side of the end of the humerus, and from the relations of the parts it was believed that it was altogether in front of the external condyle.

The patient was anæsthetised and the bones jumped quickly back into proper position as soon as flexion of the forearm on the arm was begun; so quickly indeed that further examination of the luxation was frustrated. A careful search was made, while the patient was still unconscious, for fracture but none was discovered.

The subsequent swelling of the joint and parts around was enormous but gradually subsided, aided very materially by the exhibition of Sir Henry Howse's "Usual." Passive movements were begun as soon as the swelling allowed, and recovery was complete in every respect.

PHILIP A. RANDALL.

Case for Diagnosis.

Fraserburg,
C. C.

A youth, æt. 13, brought to me one Sunday complaining of stiffness of right side of jaw and inability to open mouth properly. Found to have swelling and hardness of right side of jaw, which seemed to be chiefly in the masseter muscle of that side. On examining the inside of mouth on the same side a slight abrasion of the mucous membrane was noticed. The mouth could only be voluntarily opened for about quarter of an inch, though by the exercise of force the teeth could be separated a trifle more. Given an alkaline mixture and Tinct. of Iodine to paint over swelling.

Two days later condition much the same, but in addition to above symptoms patient complained of stiffness of left leg, no swelling of knee-joint, which moved freely but showed some stiffness on voluntary movement. A week after first seeing patient condition as follows:—Stiffness of jaws unchanged, no worse and no better; tongue showed evidence of having been bitten, this occurred while patient was sleeping. Patient complains of stiffness of lower part of back, apparently caused by some affection of lower fibres of erector spinæ. The muscles of neck seemed unaffected and head was freely movable. The left leg found to be swollen and slightly œdematous but the joints were unaffected. The heart beats eighty per minute, first sound forcible; heart dulness increased, second sound at base accentuated. Impulse diffuse on inspection. Temperature normal.

When examining the heart patient gave a start several times; this was not caused by the chest-piece being cold as it was not a metal one. Patient still under observation and treatment.

Wm. A. CARDEN.

Notice.

GUY'S HOSPITAL.

Examination for Final F.R.C.S. Eng. and University Degrees in Surgery.

A Six Weeks' Course of Classes in the following subjects will commence during the second week in October:—

Clinical Demonstrations.—C. J. Symonds, M.S. Lond., and L. A. Dunn, M.S.

Operative Surgery.—F. J. Steward, M.S. Lond.

Surgical Pathology.—G. Bellingham Smith, B.S.

Surgical Anatomy.—C. H. Fagge, M.S. Lond.

Four afternoons in each week are set aside by the Surgeons of the Hospital for Clinical instruction, which candidates who join the classes above mentioned are entitled to attend.

The Fee, inclusive of Operative Surgery, to Guy's men, is £10 10s.

Entries should reach the Dean on or before Saturday, October 13th.

Further particulars may be obtained on application to the Dean, Guy's Hospital, London Bridge, S.E.

Appointment.

NURSES.

Miss Jessie F. Ballantyne has been appointed Matron to the Incorporations Infirmary, Shirley Warren, Southampton. She was trained at the Cottage Hospital, High Barnet, and Guy's Hospital, London, and has since been sister, night superintendent, and assistant matron at Lewisham Infirmary.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Importance of Class Teaching.

DEAR MR. EDITOR.—In your comments upon the highly satisfactory results achieved by our school in the recent examinations at the University of London, there appear one or two very debatable statements with regard to education which I think should not be allowed to pass unchallenged.

The first statement I would call in question is the following: "It is contrary to the established facts of teaching experience to assert that classes are of equal efficiency to individual tuition." Can this really be the opinion of the Editor of the GAZETTE published within the walls of Guy's Hospital? It sounds more like an extract from the prospectus of a tutorial college or from the advertisement of a private crammer. Any pass examination whose lists showed that the individually tutored student was pre-eminently successful would surely stand condemned as a useful factor in education. Is not the recent reform of the University of London the result of an attempt to remove the reproach that such has been the case with some of its examinations in the past? In the faculty of medicine it is true that the examinations have been freer from this defect than in any other faculty, and I believe that the modifications of the medical curriculum, some of which you characterise as "Gilbertian in their ludicrousness," will nevertheless be found to still further eliminate cramming as a profitable employment for medical undergraduates. Your annotation continues: "Similarly the efficiency of a class varies inversely as the number in the class." Is this the explanation of the fact that while we who have, I believe, the largest University classes in London have, as you point out, recently passed 85 per cent. of our students, the massed totals of the other schools showed a pass percentage of only 45 per cent.

I hope intending London University students next October will draw an entirely opposite conclusion from these figures, and rightly believing that large classes tend to enthusiasm, mutual interchange of ideas, and intellectual development, will not choose their schools according to the principle you have enunciated. I am confident that they will not. On the contrary, the tendency will continue for students to concentrate themselves in a few schools, and to demonstrate that they at least do not agree with the deduction drawn from the two statements already quoted that, "any more in the direction of concentration must be ultimately to the harm of the general standard of knowledge."—I am, yours sincerely,

LAURISTON E. SHAW.

August 18th, 1903.

Guy's Hospital Chapel (Students') Choir.

DEAR SIR,—During the last month I have received resignations from various members who have recently qualified and are therefore about to leave the hospital.

The marked improvement of the services since the formation of the choir makes me feel justified in appealing for new members.

May I again be permitted to point out that membership of the Chapel Choir only entails duty on one Sunday in the month.

Application in writing should be addressed either to the Choirmaster, Mr. Henry Taylor, or to myself,

R. FELTON, Hon. Sec.

Death of Themistocles.

DEAR SIR,—It was pointed out to me the other day that Themistocles and many other historical persons poisoned themselves and died after drinking bull's blood. I was asked for an explanation, and not being able to find one, my questioner suggested that the presence of cyanides, or of hydrocyanic acid, in the blood might account for its toxic effects.

Perhaps some of your readers may be able to enlighten us on this matter, and Dr. Stevenson may be able to give us the toxic dose of the substance in question or state, as seems possible, that the whole tale is a fabrication.—Yours faithfully,

B. E. N.

Passim.

The result of the Preliminary Scientific M.B. has added to the delight of the statistician and to the complacency of the teachers. Our heartiest congratulations to Dr. Wade, and to his colleagues on the results, which will be found elsewhere. Out of twenty-three candidates four were ploughed and nineteen passed, including two Honours and five in the First Division. These figures give point to the admirable letter that we have the privilege of publishing in another column. As the late Dean so justly points out the results of our work give no support to the theory that large classes are cumbersome, and that individual tuition is preferable to the present system. Whether it be that the determination of the London University Examiners to encourage the solid general reading of the subjects at the expense of the coached and spoonfed "crammer" has been successful, or that the teaching and course is thoroughly practical and sound, or that the level of application and intelligence is rising we know not and seek not here to enquire, though personally we consider the results a triumph for the policy that has been observed at Guy's. In our next issue we hope to publish an authoritative forecast of the future of the London School of Medicine as it may affect ourselves.

On the historic First of October the annual reunion of the Past and Present will take place at the House Dinner of the Students' Club, under the auspices of their President, Dr. Pye-Smith, F.R.S., Consulting Physician. It is only to be expected that all who are able will avail themselves of their right to be present, and that freshmen and "pastmen" will meet on common ground. Following an arrangement intended to be a permanent institution, the President of the Clubs' Union, Mr. Robert Gordon, will be the guest of the evening, and his genial popularity will ensure him a great reception. The Treasurer will also be present and will be supported by a great number of the Staff, and we hope to see the room crowded at 7 p.m. on October 1st, and especially we would urge all the Freshmen to make a point of turning up.

In nothing is the traditional alertness of the Medical School office shewn than in their ready adaptation of lectures to the idiosyncracies and tendencies of the Universities. The strong line that the University of Cambridge, amongst others, has taken, and the serious views on Pathology that they have required of their candidates, has not been lost on the authorities, and we are glad to notice that it has been decided to hold special courses of instruction in General Pathology and in Pharmacology in October next. The requirements in these subjects by both the Universities of Cambridge and London, have been somewhat increased lately, but with the courses above mentioned, in addition to those already given in Microscopical Pathology, Bacteriology, and Morbid Anatomy, etc., and work in the post-mortem room, there will be ample opportunity afforded to university students, as well as others, for gaining the necessary experience in all branches of Pathology, and the same applies to Pharmacology.

The vast size and complicated nature of the scheme for converting the shadowy, almost titular University, into a residential teaching University with its inevitable centralization, will be at once apparent, and there will be found few to cavil at the splendid worth of the idea. It is right and desirable that the mightiest and wealthiest city in the world, the centre of the British Empire, should possess a University to teach and guide the brains that are to rule the same, and enormous though the task may be

and long the wait, we are confident that the great University that is slowly and quietly assuming shape and form at the Imperial Institute, will eventually be worthy of itself and its founders. But it behoves us to examine closely the effect on ourselves and our ancient school, and to see that no step we take should imperil the position we have inherited, and to this end we hope to publish a sketch of the possibilities and probabilities of the future.

THE temporary Medical School Offices were opened quietly and unostentatiously in the middle of this month, and a placard pointed the way to the airy and spacious rooms they now occupy. By some mishap, doubless the result of the stormy weather, the hand pointed direct into the nursing home, but this is now remedied. There is a palatial, though as yet unfurnished, room in which medical committees and so forth will sit. The offices are above the Wills Library, in the building that till recently served as the temporary Nurses' Home.

THE return of the Secretary to the Students' Club brought about promptly the closing of the Pavy Gymnasium to the unruly frequenters thereof, and its use has reverted entirely to those for whom it was originally declared. The windows are in a state of apparently spontaneous fracture, and the inside generally is somewhat battered. There can be no half-way between allowing horseplay, stump cricket, or football, after facing the necessary expense of fitting the gymnasium up as such, and the alternative of keeping it to the use it was originally intended. Personally, while wishing to retain its usefulness as a gymnasium, we would willingly support a proposal to alter it if possible into an exercise ground for Residents, for such excellent games as stump cricket and "baby footer." In the meantime the enforced Resident can recreate in the racquet court and the swimming bath.

THE marvellous and smooth tongued Green Book that emanates from the Dean's office has been enlarged, altered, and improved by the addition, among other novelties, of three photographs of the three most striking possessions of the modern student, the palatial and dignified Wills Library, the clean and cooling Swimming Bath, and the most glorious achievement of the last generation, the magnificent Pavilion and Cricket Ground at Honor Oak Park, now on three sides surrounded by villas. There is no life in any photographs; perhaps that was, however, impracticable.

THE *Guyoscope* copies that we appealed for we have now received except No. I., a copy of which, with its cover, we should be glad to receive if any reader can spare it, and the Bodlean Library will soon be complete as regards this remarkable, if unorthodox, publication.

BY permission of the Bishop of Lahore, who has also subscribed, a memorial brass will be placed in Lahore Cathedral in memory of Lieut. F. W. Sime, I.M.S., son of Dr. Sime, formerly director of public instruction in the Punjab, whose early death in Somaliland with Colonel Plunket's column is fresh in our minds. Of Dr. Sime's three sons, two have died in the public service, and the third is now on service in Somaliland. A considerable sum has been subscribed in England by his friends, and Mr. W. Bell, Director of Public Instruction, The Punjab, will be happy to acknowledge any further contributions, which should be made without delay.

A GENEROUS donor has passed away in the person of Mr. Edward L. Raphael, a brother of the founder of the Henrietta Raphael Nursing

Home. Like so many of his family and religion, he was a liberal supporter of charities, endowing a ward at the London, and giving us large sums of money, and we offer our sincere condolences to his nephews.

One of the most distinguished members of the medical profession, Dr. Joseph Griffith Swayne, M.D. London, M.R.C.S., died at his residence, 74, Pembroke Road, Clifton, Bristol, in his 84th year. Dr. Swayne was a son of the late Mr. John Champney Swayne, Surgeon, of Bristol, and grandson of the Rev. George Swayne, formerly sixty years vicar of Puckle Church, Gloucestershire. Born in Bristol in October, 1819, Joseph Griffiths Swayne was educated at Bristol College from 1831 to 1836, and studied further at the Royal Infirmary, General Hospital, and Guy's Hospital, London, becoming M.R.C.S., L.R.C.P., in 1841. He graduated at London University in 1842 (taking gold medals in medicine and midwifery), and M.D. in 1845. He became Fellow of the Obstetric Society, London, and Emeritus Professor of Midwifery at University College, Bristol. He was lecturer at the Bristol Medical School for fifty years, Consulting Obstetric Physician at the General Hospital, and Honorary Physician to the Children's Hospital and Clifton Dispensary. A work from his pen entitled "Obstetric Aphorisms for Students," was translated into several languages, and until recent years he wrote largely for medical papers.

The Israelites complained of being expected to make bricks without straw, but it is quite possible that the Pyramid Gazette Editor would have complained still more had he been obliged to produce Passim in August without any accident to furnish a theme. In August the wards are not full, the staff are holiday-making, a leisure none grudge them, and the general attitude of the park is one of leisured repose and peaceful siesta.

In these circumstances the distracted writer appeals to the Editor and critic for suggestions, and he is referred to the Englishman's usual topics, the weather and the innovations. Of the former, accustomed as we have been to record performances this year, viz., the athletic triumphs and the record pass list, we can still find fresh, though melancholy novelty in the wettest summer on record, and the most wildly unpleasant weather that the far-famed English climate has ever been responsible for. The park is almost deserted, no warm enervation saps the man on the spot, and the discontent is universal.

All around gangs of workmen solemnly improve, repair, and create, but over the inmates prevails a snappy enervating leisure that all devoutly hope will soon pass. Truly London in the holiday season is an unpleasant place What wonder the general temperament is dyspeptic, and that even the vagaries of the lady doctor, and the manœuvres of Captain Barr, hardly excite more than sarcasm and discontent. And yet the returning travellers from the Alps, the riverside, the delightful recesses of the country and elsewhere, are glad to get back to the familiar scene.

The sameness of the places pleasant, the nurses' uniforms in the park, the broken limbs in the colonnade, the old and familiar faces exercise that attraction that we all feel most when just returning, and the familiar cackle of the thronging crowd of wardmaids that used to jar, now merely seems familiar.

NOTICE TO CORRESPONDENTS

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Nursing News.

Matron's Office.

On July 6th, Nurse Perriam left the hospital on completion of her three years' training. Probationer Browning has been appointed to succeed her as Head Nurse in Lazarus ward.

On July 7th, Nurse Maddison left the hospital on completion of her three years' training to take up her duties on the staff of the Private Nurses' Institution. Nurse Essex was transferred from Ruth to Cornelius, and Probationer Gilbert appointed Head Nurse in Ruth temporarily.

On July 11th, Nurse Ward, Head Nurse in Mary ward, left the hospital on completion of her three years' training.

On July 13th, Nurse P. Manning, Head Nurse in Bright ward, left the hospital on completion of her three years' training. Probationer Plant has been appointed to succeed her as Head Nurse in Bright.

On July 20th, Nurse Witchell, Head Nurse in Bright ward, left the hospital on completion of her three years' training, and Nurse L. Wood was appointed to succeed her as Head Nurse in Bright.

On July 29th, Nurse Dixon, Head Nurse in Bright ward, left the hospital on completion of her three years' training. Probationer Fox has been appointed to succeed her as Head Nurse in Bright.

On August 4th, Nurse Pettitt, Head Nurse in the Outpatients' Department, Nurse Byrne, Head Nurse in Stephen, and Nurse Lowenthal, Head Nurse in Astley Cooper ward, left the hospital on completion of their three years' training. Nurse Wheatley, Head Nurse in the Theatre, was transferred to Stephen, and Nurse Horsepool, Head Nurse in Astley Cooper, to the Theatre. Probationer Harden was appointed to succeed Nurse Lowenthal as Head Nurse in Astley Cooper ward.

On August 5th, Nurse Windemer, Head Nurse in Bright ward, left the hospital on completion of her three years' training.

On August 11th, Nurse Collie, Head Nurse in Charity, left the hospital on completion of her three years' training, and Probationer Leonie was appointed to succeed her as Head Nurse.

On August 18th, Nurse Dann, Head Nurse in John, left the hospital on completion of her three years' training. Nurse Purse, Head Nurse in Queen ward, was transferred to John, and Probationer Porter appointed Head Nurse in Queen.

On August 19th, Nurse Tweedie, Head Nurse in Job ward, left the hospital on completion of her three years' training to take up her duties on the staff of the Private Nurses' Institution, and Probationer McFarlane was appointed to succeed her as Head Nurse in Job.

The following Probationers have been successful in passing the Surgical Examination held on June 25th, 1903. 1st Class.—Probationers Bonser, du Santoy, Tippetts, Ponzoni, H. Edmonds, Yeates, Kirby, Oliver, G. Harvey, Abbott, Elvin, Martin, Smith, Douglas, Stones, Monnickendam, Bell, E. Stanton, Jones, Knapp, Leather, Rigby, Frazer, Hedgecock, Barnard, Jickling, Powell, Auld, Armstrong, Crerar, Hucklesby, Newton, Shewell, Jolley, E. Smith, Halford, F. Evans, M. Adams, Blott, Waterman, Waldron, Bryant, Wright, Bailey. 2nd Class.—L. Scott, Danson, Bevan, Atkinson, Bromwich, Dawson, Gregory, Nunn, Crocker, Pritchard, D. Humphery, Austin, Cawes, Aitken, Whittam, Lowe, Johnston, Stein, Clutton, Morton, Cannell, Sleigh, Seccombe, Arundel, Sheldon, Dredge, Dibblin, Woods, Shaw, Faull, Coulson, G. Evans, M. Hughes, Pedler, Holman, Spicer, Parkins.

Pass List.

University of London.

INTERMEDIATE SCIENCE.

EXAMINATION FOR HONOURS.

Chemistry.—Third Class.—H. A. Sanford.

Zoology.—Third Class.—H. A. Sanford.

Honours Candidate recommended for a Pass.

S. G. Tracy.

PRELIMINARY SCIENTIFIC EXAMINATION.

ENTIRE EXAMINATION.

First Division.—M. M. Adams, H. B. Carter, E. L. M. Hobb, T. Stansfield, H. Stott.

Second Division.—S. Chelliah, W. Johnson, A. E. Lees, P. S. Price.

Chemistry and Experimental Physics.—*S. S. Brook, *G. B. Harland.

Biology.—*M. E. Ball, *J. B. Dunning, *K. H. Hole, *H. C. Lucey, *B. McDermott, N. A. D. Sharp.

* Denotes completion of examination.

Final Conjoint Examination, July, 1903.

Medicine, Surgery and Midwifery.—*K. Black, *P. A. Peall, *C. D. Pye-Smith.

Medicine and Surgery.—*C. F. Fraser.

Medicine and Midwifery.—S. C. Bowle.

Medicine only.—R. G. Anderson, *J. S. Cooper, *J. Goss, R. A. Greeves, *G. W. C. Hollist, R. Moyle, *A. P. Piggot, H. L. Shelton, F. H. Wallace.

Surgery only.—*P. R. Bolus, P. P. Cole, J. B. Copland, *C. E. Iredell, *C. H. Reinhold, *H. D. Smart, *F. L. Thomas.

Midwifery only.—H. O. M. Beadnell, J. C. O. Bradbury, G. F. Hardy, F. P. Hughes, *R. Larkin, M. G. Louisson, W. T. P. Meade-King, *E. H. B. Milsom, C. S. Morris, G. F. Rey, G. A. Ticehurst, *N. I. Spriggs, A. M. Webber, R. Willan.

* Denotes completion of examination.

First Conjoint Examination.

Chemistry and Elementary Biology.—L. M. J. Menage, D. C. Roberts.

Chemistry.—A. Angell, A. D. Vernon-Taylor, A. Harris, S. D. Marshallsay, D. G. Wearing, J. S. Vogwell.

Practical Pharmacy.—T. R. Harvey, W. Johnson, W. T. P. Meade-King, G. H. Morris, M. J. Mottram.

Biology.—J. Nairn, F. C. V. Thompson.

PRELIMINARY SCIENCE (L.D.S.)

Practical Pharmacy and Elementary Biology.—C. E. Price.

School Examination in Elementary Anatomy, July, 1905.

A. C. Dickson, T. Evans, F. J. Gillett, F. A. Husbands, E. P. Joynt, H. F. Joynt, C. L. Leipoldt, J. W. Mawer, J. B. Mawer, C. H. Mills, H. M. Peacock, C. L. Taylor, W. W. Vaughan, H. E. Warren-Williams, J. N. Watson, H. J. Snowden, P. E. Luce, W. H. Yeo.

Novelties.

AN INHALER FOR THE ADMINISTRATION OF SOMNOFORM.

The accompanying illustration represents an apparatus which I have now used for some months for the administration of somnoform, consisting of a celluloid face-piece connected by means of a right-angled metal tube to a rubber bag. The face-piece is lined with lint which is maintained in position by a special spring, horseshoe in shape, preventing collapse of the lining during any deep inhalation by the patient. The lint can be thus readily changed and a clean piece substituted. In using this apparatus, the dose of somnoform required for a single administration, and producing an anæsthesia averaging from 90 to 120 seconds, is about 2½ c.m., *i.e.*, half the dose of the drug marked on the bottles in which it is supplied for use with the handkerchief cone adopted by Dr. Rolland.

The apparatus was made for me by, and can be obtained from, Messrs. Down Bros., 21, St. Thomas's Street, S.E.

(Signed) R. H. JOCELYN SWAN,
M.S. Lond., F.R.C.S.

8, St. Thomas's Street,
London Bridge, S.E.

NESTLE'S MILK.

There is no greater problem for the poor mother of a Borough family than the providing of milk for her numerous progeny in the summer months.

The milk supplies often are so relatively expensive that the family cannot afford sufficient "cow's milk." The reason for this is that the milk is often thin and watery and swarming with germs, and very often on the point of going sour, even at Guy's this is not unknown.

In the result the mothers fall back on patent foods (rarely), adults' food commonly, and tinned milk at times. The latter is perhaps the best of a bad bargain under the circumstances. Messrs. Nestle's milk is well known and has stood every test in the laboratory and in the wards. In the absence of fresh and pure milk, surely one of the rarest of boons in London, Nestle's milk, diluted beforehand to the required consistence is the best substitute available, and we can thoroughly recommend it for its invariable quality. We have used it *ourselves* in studies at school, on yachts, in holidays, and know its virtues first hand.

Change of Address.

Dr. Edward Ibotson has removed from 1, Talbot Square, Aberavon, to 1, Barton Road, Dover.

W. J. Rowland has removed from 10 to 5, College Road, Brighton.

S. Herbert Longhurst, L.S.A. Lond., L.D.S. Eng., has removed from 28, Old Burlington Street, W., to 41, Devonshire Street, Portland Place, W.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Sport.

Cricket.

GUY'S v. ST. MARY'S

FINAL CUP-TIE.

Played at Honor Oak Park on Monday and Tuesday, July 13th and 14th, and resulting in a win for Guy's by an innings, 4 wickets and 189 runs.

Langdale won the toss and sent in O'Brien and Morres. Three wickets soon fell for 53 runs, but Barber and Willan raised the score to 234 ere the former was out for an excellent innings of 101, this being his third century this season. Collins and Willan were the next to leave, the latter having played good cricket for his 80. On Morgan joining Wyatt a great stand was made, 270 runs being added during their unbroken partnership. Runs came at a tremendous pace, 370 being added in the two hours and a half play after lunch, 130 only occupying half an hour at one period. Both men played delightful cricket, scoring well on both sides of the wicket, and when Langdale declared at a quarter to five o'clock the total was 573 for six wickets. This is a record score for cup-ties, and obtained in record time. In the hour and fifty minutes left for play, four of our opponents were dismissed for 112 runs, and on resuming next day, the remaining six were disposed of in an hour and a quarter for an additional 140 runs, the total being 252. Following on, Foster, who was bowling exceedingly well and very fast, quickly dismissed the first four batsmen, and the second innings terminated at a quarter past three, leaving us winners as stated. We have now won both the cricket cups and all the football cups, which is a record for any hospital I believe. In the evening the Residents kindly invited the team to dinner at the college, and a highly enjoyable evening was spent. Scores:—

GUY'S.

F. Morres, c Greene, b Causton	32
A. B. O'Brien, lbw, b Causton	6
H. M. Langdale, c Finlayson, b Causton	5
R. Willan, lbw, b Causton	80
H. Barber, lbw, b Ling	101
H. D. Wyatt, not out	166
E. A. Collins, c Finlayson, b Field	34
E. Morgan, not out	132
Extras	17
Total (6 wickets)	573

A. L. Foster, L. G. Davies, M. G. Louisson, did not bat.

ST. MARY'S.

	1st Innings.	2nd Innings.
G. B. Norman, b Davies	58	c Louisson, b Foster 3
A. R. Littlejohn, b Wyatt	16	b Foster 10
E. C. Hobbs, b Foster	3	b Foster 9
S. P. Causton, b Foster	33	c Collins, b Foster 16
E. C. Bradfield, b Davies	15	not out 32
H. S. Ollerhead, c & b Foster	2	c Foster, b Wyatt 8
W. T. Finlayson, c O'Brien, b Foster	96	c Langdale, b Wyatt 16
W. H. C. Greene, c Langdale, b Wyatt	6	c Wyatt, b Foster 16
S. Field, c Davies, b Wyatt	2	c Morgan, b Davies 8
A. T. Gaye, not out	8	c & b Wyatt 2
G. P. Hawker, b Foster	3	b Davies 1
Extras	10	11
Total	252	132

GUY'S v. GRAVESEND.

Played at Gravesend on Wednesday, July 1st. The teams were most hospitably entertained to lunch by Dr. Bryden, to whom our best thanks are due for his generosity. Scores:—

GUY'S.

F. Morres, c Tabrum, b Boorman	0
T. C. Lucas, b Casteley	12
R. Willan, Junr., b Casteley	8
A. E. Collins, c Tabrum, b Casteley	35
H. D. Wyatt, b Casteley	57
A. Cawston, st Tabrum, b Sarel	10
R. Willan, Sen., c Boorman, b Casteley	4
H. M. Langdale, c Sarel, b Casteley	66
M. Macpherson, not out	47
M. R. Smith, c Troughton, b Casteley	0
F. Young, lbw, b Casteley	1
Extras	22
Total	262

GRAVESEND.

L. H. Troughton, c Morres, b Wyatt	50
N. Cockell, c Collins, b Willan, Senr.	11
A. Stevens, b Morres	8
W. M. Sarel, lbw, b Wyatt	17

J. Casteley, c Collins, b Willan, Senr.	49
F. W. Boorman, not out	27
Extras	8
Total (5 wickets)	170

Tabrum, Troughton, Dr. Bryden, and two others to bat.

GUY'S v. BEXLEY HEATH ASYLUM.

Played at Bexley on Saturday July 4th. The wicket was very crumbly and fiery, and two innings apiece were almost completed in consequence. Scores :—

Guy's.

	1st Innings.		2nd Innings.
F. Morres, c Barrs, b Everett	11	b Keenan	6
R. Willan, run out	39	c & b Barrs	4
H. M. Langdale, c Randall b Everest	11	c Barrs, b Everest	20
A. B. O'Brien, c Randall, b Everest	5	run out	10
H. D. Wyatt, st Nailor, b Everest	4	c Randall, b Barrs	0
E. A. Collins, c Badcock, b Keenan	3	c Mitchell, b Keenan	8
E. Morgan, b Keenan	33	st Naylor, b Everest	12
O. V. Payne, b Keenan	1	not out	20
T. E. Edey, c Barrs, b Everest	1	c Naylor, b Barrs	0
J. S. Donnell, not out	0	c Barrs, b Everest	26
W. H. Burney, b Everest	0	b Everest	8
Extras	12		10
Total	120		124

Bexley Asylum.

	1st Innings.		2nd Innings.
C. P. Keenan, b Morgan	15	not out	18
H. Mitchell, b Wyatt	9		
J. Badcock, c Burney, b Wyatt	4	c Collins, b Wyatt	4
H. Grace, c & b Wyatt	12		
W. Naylor, lbw, b Wyatt	4	c Edey b O'Brien	12
W. Benger, b Morgan	4	st Collins, b O'Brien	3
F. Barrs, c O'Brien, b Wyatt	10	c Willan, b Wyatt	12
A. Randall, b Morgan	1		
G. Everest, not out	3		
H. Dyson, c Morgan, b Wyatt	0		
H. B. Short, b Morgan	2		
Extras	9		6
Total	73	(4 wickets)	55

GUY'S v. WISETON PARK.

Played at Captain Laycock's place, Wiseton Hall, on Tuesday and Wednesday, July 7th and 8th, and resulting in a win for us by the large margin of four wickets and 415 runs. The team was splendidly housed and entertained by Captain Laycock, and a most enjoyable time was spent. Sir Alfred Fripp, by whose means the match was arranged, was also a guest, and was delighted with our success. Our very best thanks are due to Captain Laycock for the splendid time which he gave us and for his generous hospitality. Guy's won the toss, but only put together 168 runs in the first innings, of which Langdale made 49 by excellent cricket. Our opponents were dismissed for 146, Wyatt bowling splendidly, taking seven wickets for 77 runs. There was an hour and fifty minutes left for play, and in that time Barber and Morres put on 243 runs without loss and were not out at the close. Resuming on the following morning, 351 was totalled ere Barber left for a magnificent innings of 185. He hit 29 runs and scored at a great pace throughout. Morres increased his score to 176 by free hitting before he retired, his innings being free from chance. This total of 351 for first wicket is, I believe, a new record for the hospital. Wyatt, Harris and Foster brought our total up to 535 by free hitting, and at lunch we declared at this total. Our opponents were again dismissed for the small total of 142, thanks again to Wyatt, who captured seven wickets for 18 runs, who thus took in all 14 wickets for 158 runs, a fine performance on a hard, true wicket. Scores :—

Guy's.

	1st Innings.		2nd Innings.
H. Barber, c Goodacre, b Gayler	37	c & b Goodacre	185
F. Morres, c Hudson, b Peatfield	6	c Batty, b Leather	176
H. M. Langdale, b H. C. Farmer	49	b Gayler	6
R. Willan, b Goodacre	6	b Goodacre	5
H. D. Wyatt, b H. C. Farmer	18	b Gayler	40
Harris, c Goodacre, b Duxfield	4	not out	51
E. A. Collins, c & b Guyler	21	st Hudson, b Goodacre	50
A. M. Tolhurst, b H. C. Farmer	4		
A. L. Foster, b H. C. Farmer	8		
F. D. S. Jackson, c Gayler, b H. C. Farmer	0		
G. N. Bartlet, not out	0		
Extras	15		22
Total	168	Total (6 wickets)	535

Wiseton Park.

	1st Innings.		2nd Innings.
J. Duxfield, c Langdale, b Wyatt	0	lbw b Wyatt	4
E. E. Peatfield, b Wyatt	17	b Harris	17
W. B. Goodacre, c Langdale, b Wyatt	12	c & b Wyatt	14
Dr. Heasman, c Willan, b Wyatt	25	b Morres, b Wyatt	48
Rev. Farmer, b Wyatt	28	c Langdale, b Wyatt	0
H. C. Farmer, b Wyatt	17	c Tolhurst, b Wyatt	18
K. T. W. Leather, st Collins, b Wyatt	25	b Wyatt	8
Captain Grove, b Foster	9	lbw b Wyatt	4
F. Guyler, c Barber, b Foster	0	c Wyatt, b Harris	20
G. Hudson, not out	2	c Collins, b Harris	4
E. Batty, b Foster	0	not out	0
Extras	14	Extras	5
Total	146		142

GUY'S v. ADDISCOMBE.

Played at Honor Oak on Saturday, July 11th, and resulting in a drawn game. The match was a half-day one. Scores :—

ADDISCOMBE.

F. R. Warren, b Morgan	32
F. W. Robarts, lbw, b Morgan	12
H. G. Roberts, c Willan, b Norton	59
R. S. Turner, not out	56
A. Wiltshire, b Norton	8
C. Ashcroft, not out	58
Extras	9
Total (4 wickets)	234

M. Moore, A. C. Beaton, F. G. Curry, V. Darvill, H. Brown, did not bat.

GUY'S.

F. Morres, b Brown	0
E. Morgan, c Ashcroft, b Brown	9
A. B. O'Brien, c Turner, b Darvill	15
H. M. Langdale, b Brown	23
R. Willan, Junr., b Brown	0
E. A. Collins, c Moore, b Darvill	13
M. G. Louisson, b Darvill	1
E. L. R. Norton, not out	15
R. Willan, Senr., not out	9
Extras	5
Total (7 wickets)	91

R. W. Allen and S. C. Bowle did not bat.

GUY'S 2ND XI. v. OLD OLAVIANS.

The return match with this team resulted in an easy win for Guy's. We declared with six wickets down for 248, to which Bookless, Husbands and Tolhurst were the chief contributors. Our opponents were all dismissed for 115. Scores :—

GUY'S.

F. A. Husbands, c & b Fryer	64
A. M. Tolhurst, b Fryer	56
J. S. Bookless, b Lowe	86
O. V. Payne, b Brownlow	0
H. H. Carter, run out	15
E. W. Strange, c Wakeley, b Howard	13
W. A. Helyar, not out	8
Extras	6
Total (6 wickets)	248

Innings declared closed.

Bartlett, Nairn, Gardiner and Bentley did not bat.

OLD OLAVIANS.

P. Brownlow, c Payne, b Bartlett	16
S. G. Fryer, b Bartlett	3
F. B. Lowe, c Bookless, b Bartlett	17
W. B. Owen, c Bartlett, b Bookless	10
Tagg, st Payne, b Bookless	4
L. D. Wakely, b Bookless	3
H. Wakely, c Bookless, b Bartlett	6
C. Thane, c Tolhurst, b Bartlett	7
J. A. Griffin, not out	20
A. Howard, b Bartlett	13
S. W. Barnder, b Tolhurst	2
Extras	14
Total	115

GUY'S 2ND XI. v. MANOR HOUSE SCHOOL.

This—the last match of the season—was played at Honor Oak on July 15th. The match was drawn, both sides scoring well. Scores :—

GUY'S.

R. Willan, Senr., run out	8
E. W. Strange, b Laird	11
E. L. Norton, not out	107
G. F. Allison, run out	69
H. H. Moyle, not out	5
Extras	27
Total (for 3 wickets)	227

Macpherson, Gibson, M. R. Smith, Bookless, Tolhurst, Bush, did not bat.

MANOR HOUSE SCHOOL.

A. L. Gorringe, run out	52
A. C. Dene, b Willan	47
A. Martyn, c M. R. Smith, b Willan	12
S. Maxwell, c	6
R. M. Horner, not out	3
H. M. Gorringe, not out	17
Extras	11
Total (for 4 wickets)	148

Laird, Page, Canttlere, Evans, Parson, did not bat.

GUY'S 3RD v. NEW ELTHAM.

This match, played at New Eltham, Saturday, July 11th, ended in a win for New Eltham, by 11 runs. Scores :—

NEW ELTHAM.

Warren, c Eccles, b Wearing	16
Barton, c Whittell, b Wearing	22
Wallace, c Reynolds, b Wearing	0
Blakiston, c Eccles, b McEvedy	20
Murphy, c Reynolds, b McEvedy	9
Haggerty, run out	1
Rossell, b Harvey	1
Sayers, b McEvedy	6
Bower, st Eccles, b Moyle	10
Pace, not out	0

Parker, c Edey, b Moyle	0
Extras	16
Total	101

Guy's.

A. D. Vernon-Taylor, run out	0
T. H. Edey, c & b Warren	1
H. H. Moyle, lbw, b Wallace	9
T. R. Harvey, c Parker, b Barton	18
P. F. McEvedy, b Burton	10
W. H. S. Burney, b Wallace	7
D. Reynolds, c & b Wallace	17
D. G. Wearing, not out	15
H. M. Whittell, b Wallace	0
H. F. Wight, b Wallace	4
H. N. Eccles, b Wallace	2
Extras	7
Total	90

CRICKET SEASON, 1903.

The season has been a highly successful one, the team winning eight matches, losing five, and drawing five. The 2nd XI. have done extremely well, and have not lost a match. Both the Senior and Junior Cups were brought back again to Guy's, this making the thirteenth time in which we have won the Senior Cup since 1882. Barber is to be congratulated on his fine average of 72 for eight innings, in which he three times scored over a century. Centuries were also scored by Morres, 177; Wyatt, 166 not out; and Morgan, 132 not out, for the 1st: and Bookless and Norton for the 2nd XI. The only thing to be regretted is that some of the team turned out so irregularly.

BATTING AVERAGES.

	No. of Inns.	Total No. Runs.	Times not out.	Highest Score.	Average.
H. Barber	8	582	0	185	72·75
F. Morres	20	640	0	177	32
H. D. Wyatt	12	345	1	166*	31·36
E. Morgan	14	333	1	132*	25·61
H. M. Langdale	20	489	0	88	24·45
L. G. Davies	9	167	1	45	20·87
A. B. O'Brien	13	221	1	38	18·41
A. L. Foster	9	139	1	50	17·12
R. Willan	20	310	0	80	15·5
E. A. Collins	19	239	2	35	14·05
M. G. Louisson	5	29	2	12	9·6
Also batted.					
J. S. Bookless	5	68	0	36	13·6
M. Macpherson	9	90	2	47*	12·85
F. Husbands	4	36	0	28	9
F. Young	4	9	1	8	3
E. L. Norton	2	34	1	19	34

* Not out.

BOWLING AVERAGES.

	No. of Runs.	No. of Wkts.	Average.
A. L. Foster	388	26	14·92
L. G. Davies	370	23	16·08
H. D. Wyatt	743	43	17·27
A. B. O'Brien	350	20	17·5
E. Morgan	398	21	18·95
Also bowled.			
H. Barber	5 wickets for 55 runs.		
H. M. Langdale	5 " 39 "		
Harris	3 " 43 "		

The last match of the season was played on July 15th. The 2nd XI. has been very successful. There were twenty-two matches arranged including Cup ties; of these fourteen were played—nine being won, five drawn. In the Cup matches St. Thomas's were beaten at the second attempt in the semi-final. Bart's. in the final had to face a total of 323—of these they only succeeded in making 140. The new Junior Cup thus becomes our property for its first season. Success has been due to consistent batting by Tolhurst, Bookless, Norton and Husbands—who have been well supported by Allison and Greening. The bowlers have done good work all through the season. A little improvement in the attack, however, would make the team a much stronger one. We must always hope to have such a keen side to represent the Hospital for the Junior Cricket Cup.

BATTING ANALYSIS 2ND XI. (100 runs).

	No. of Inns.	Total No Runs.	Times not out.	Highest Score.	Average
Bookless	5	294	1	101*	73·7
Norton	7	261	2	107*	52·2
Husbands	6	249	1	72	49·8
Tolhurst	11	358	3	72*	44·7
Allison	7	199	—	69	28·4
Greening	8	174	—	66	21·7

* Not out.

BOWLING ANALYSIS (10 Wickets).

	O.	M.	R.	W.	Average.
Russell	69·3	21	115	22	5·2
Tolhurst	32·2	2	100	11	9·2
Piper	62	18	156	17	9·2
Bartlett	130·3	32	348	36	9·6

Guy's Hospital Rifle Association.

The season which has just been completed has been eminently satisfactory in one sense at least. We have, we believe, attained an object determined upon at the beginning of this year, namely, that of bringing the Rifle Club into a more prominent position among the constituents of the Clubs' Union than it has taken for some years. The existence of two Shooting Challenge Cups has been practically forgotten at Guy's, except among the inner circle of the Association, but we feel sure that

everyone will now agree that both trophies are an addition to our collection of plate that does not deserve to be overlooked. It rests with the authorities quite as much as ourselves that the Association shall maintain this position.

During the season we have had at least ten members shooting regularly, with nearly as many to fall back upon in necessity.

Out of nine matches arranged, simultaneous and otherwise, we have won three and lost three, while three were scratched owing to the flooding of Runnemede ranges during the unfortunate wet weather in June. The average maintained in the "Armitage Cup" shoots is very gratifying, and the score obtained in the Bisley Cup shoot is, we believe, a record for that event under the present conditions.

The Annual Prize Meeting was hardly a success, in spite of its being held simultaneously with the U.H.R.A. meeting. The fact that only five members went down, and that the low score of 80 out of a possible 105, obtained the Newton-Pitt Cup, speaks for itself.

LIST OF MATCHES, ETC.

			For.	Agst.	Rslt.
May 9.	Old Alleynians R.C.	Runnemede	308	318	lost
„ 13.	Armitage Cup I.	„	482	—	
	Dulwich College	„	454	441	won
„ 27.	Armitage Cup II.	„	428	—	
June 6.	High Wycombe R.C.	H. Wycm.	566	669	lost
„ 10.	Armitage Cup III.	Runnemede	487	—	
	Felsted College (simult.)	„	342	329	won
„ 18.	Old Alleynians R.C. ... / G Comp., Artists R.V. / Rough-riders R.C. ...	...	...		scratched
„ 24.	Armitage Cup IV.	Runnemede	493	—	
	Malvern College (simult.)	„	448	410	won
July 6.	Whitgift Gram. Sch.	Woldingham	323	360	lost

July 1. Annual Prize Meeting.

Open Competition—

1st Prize—"Newton Pitt" Cup.		R. Felton ...	80
2nd „	... 10/- ...	F. B. Lowe...	79

Handicap Competition.

1st Prize	... 15/- ...	L. Reynolds..	96
2nd „	... 10/- ...	F. B. Lowe...	91
3rd „	... 5/- ...	D. Reynolds	89

July 16. United Hospitals Challenge Cup, Bisley.

R. E. French	48
G. C. F. Robinson	47
J. S. Cooper	45
R. Felton	43
F. B. Lowe	42
G. A. Ticehurst	41
Total	266

2nd. St. Thomas's. Total 234.

3rd. St. Bart.'s } Scores not obtained.
4th. St. George's }

Appointment.

CIVIL.

Fox, J. A., L.R.C.P. Lond., L.R.C.P., L.R.C.S. Edin., L.S.A., has been appointed Medical Officer for the No. 3 District by the Penzance Board of Guardians.

Births.

BEVEN.—On August 2nd, at Balham Hill, S.W., the wife of Octavius Beven, M.D. Durh., of a son.

DRAKE.—On the 13th inst., at 13, Mount Joy, Durham, to George Herbert Drake, L.D.S. Eng., and Clara Gertrude Drake, a daughter.

HODGSON.—On August 18th, at Westcliffe-on-Sea, the wife of Victor J. Hodgson, L.R.C.P. Lond., M.R.C.S., D.P.H. Camb., of a son (stillborn).

KITCHIN.—On August 1st, at 107, Thursby Street, Bradford, Yorks., the wife of James Tyson Kitchin, M.D., D.P.H., of twin daughters.

REYNOLDS.—On August 3rd, the wife of B. Gore Reynolds, L.R.C.P. Lond., M.R.C.S., "Collegehowe," College Park, N.W., of a son.

VAN SOMEREN.—At the Grand Hotel, Pénêgal, Mendelpass, Süd Tirol, Austria, the wife of Ernest Van Someren, M.R.C.S., etc., of Venice, of a son.

Marriages.

IBOTSON—CUMMINGS.—On August 12th, at St. Mary's Church, Aberavon, South Wales, by the Rev. D. H. Griffiths, M.A., Vicar, Edward Ibotson, M.B. London, etc., youngest son of the late Richard Revel Ibotson, B.A. London, to Susan, youngest daughter of the late John B. Cummings, of Abergaveney.

OWSLEY—TIMBRELL.—On August 12th, at St. Margaret's Church, Anfield, Liverpool, by the Rev. W. F. John Timbrell, M.A. (cousin of the bride), assisted by the Rev. John Wakeford, B.D., Vicar of the Parish, George Chetwode Owsley, M.B., son of John William Owsley, barrister-at-law, Sydenham, to Ellen, third daughter of the late Charles Frederick Timbrell, Bank of England, of Stockport.

Deaths.

SWAYNE.—On August 1st, at Pembroke Road, Clifton, Bristol, Joseph Griffith Swayne, M.D. Lond., M.R.C.S., L.S.A., in his 84th year.

TANNER.—On August 8th, at Ben Rhydding, Yorkshire, Esther (Ettie), the beloved wife of John Tanner, M.D., of 19, Queen Anne Street, London, W., suddenly, at last, after a long and distressing illness, aged 57 years.

Ed.—J. M. B.

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Notice.

All Communications, Articles, Letters, Notices, and Books or Review should be forwarded, accompanied by the name of the sender, to the Editor, Guy's Hospital Gazette, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the Gazette *bound should leave them with the Librarian.*

The annual Subscription to the Gazette *is* 6s. 6d.; *post free,* 7s. 6d *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. Wells, Secretary's Office, Guy's Hospital.

The charge for binding in blue, with the Arms of the Hospital in gold, will be One Shilling and Sixpence.

Calendar of Coming Events.

September, 1903.

Sat. 12.—Messrs. Symonds and Steward's take-in; Drs., W. M. Mollison and W. Reeve; Cl. A. R. Brailey.

Mon. 14.—First and Second M.B. Durham Examinations begin.

Names of Candidates for Entrance Scholarships to be sent to Medical School Office by this date.

Thur. 17.—Messrs. Lucas and Lane's take-in; Drs., F. Alcock and J. H. Clatworthy; Cl., K. Black.

Application to Medical School Office for Schedules for First and Second Conjoint Examinations to be made not later than this date.

Fri. 18.—Third and Final M.B. Durham Examinations begin.

Examinations for M.D. and M.S. Durham begin.

Sat. 19.—Names of Candidates for Entrance Scholarship in Dental Mechanics to be sent to the Medical School Office by this date.

Mon. 21.—Last day for applying to Registrar for Form of Entry for Final M.B. Lond.

Tues. 22.—Examination for Entrance Scholarships begins.

Application to Medical School Office for Schedules for Final Conjoint Examination to be made not later than this date.

Examination for Medical Entrance Scholarships begins.

Thur. 24.—Messrs. Golding-Bird and Dunn's take-in; Drs., A. S. Littlejohns and P. E. Minett; Cl., A. R. Brailey.

Sat. 26.—Students' Number of the Gazette published.

Guy's Hospital Gazette,

SEPTEMBER 12, 1903.

Sterility.

CLINICAL LECTURE BY PETER HORROCKS, M.D.

Gentlemen,—Although there is no patient in the wards complaining of sterility, I thought this would be an interesting subject to take for this lecture, as it will afford an opportunity of saying a few words upon a subject which is dealt with somewhat meagrely in the books, perhaps on account of its delicacy. Still, when you get into practice you will be consulted on the matter, as every medical man is at some time or other. Nowadays some women object to having children, although they get married; or if they do become pregnant they take steps to get rid of it. Nature, however, is no respecter of persons, and she punishes anything of that kind in a way which is perfectly inexorable. So the cases which you will be asked to see will probably be those where the woman when she was young agreed with her husband not to have children "for the present," and checks any pregnancy. Later on, perhaps five or six years later, they think they would like a child, having possibly become better off; and they imagine that all that is necessary is to discontinue the checks which up till now have been adopted. But they find, much to their surprise, that pregnancy does not follow; and the woman sometimes says she would give any money if only she could become pregnant. That is one form. Another is that in which the woman has a desire from the first to become pregnant, but she does not. Now I think Matthews Duncan's division of sterility into *absolute* and *relative* is the best that has ever been made. He meant by *absolute* sterility that where the patient had never been pregnant at all—no abortion nor miscarriage had occurred even. To illustrate what I mean I would say that if a woman had no ovaries at all she would not only have *absolute* but *permanent* sterility. But in *relative* sterility the woman might have

had a pregnancy or one or several miscarriages, so that there could be no doubt about the occurrence of pregnancy; but after one or two of those miscarriages, etc., the pregnancies stopped. There are further divisions made by others, such as primary and secondary sterility. For instance, a woman might have had a child, and then something happened; perhaps a considerable salpingitis, with double tubal disease, which rendered her sterile, and this is known as secondary sterility. Those subdivisions into absolute and relative, and into primary and secondary, are the only scientific divisions which have been made. But in relation to this subject it is necessary to give some attention to conception. You know conception is not synonymous with coitus. Some women will tell you that they know exactly when they conceive, that is, which particular coitus led to the condition of pregnancy. But I do not believe any woman can tell that, because conception is the union of the ovum with the spermatozoa—or a spermatozoon, because it seems clear that one active spermatozoon is enough to cause pregnancy; whereas coitus is merely the deposit of semen in the vagina. It may be some considerable time before the union occurs. You will remember I told you the other day that spermatozoa are, as it were, monociliated epithelium; and they have a tail, which enables them to wriggle themselves along the genital tract. Women who say they know the coitus which caused their pregnancy are wrong nine times out of ten; they rely upon a certain sensation. But such a sensation is not at all necessary to conception. I have a rather amusing book given to me by our late Medical Superintendent, Dr. Steel. The author tried to show that in a given connection, where you have a lot of spermatozoa of different degrees of vitality, it was the strongest that reached the ovum. At any rate, it is certain that conception means the union of the two, and that that does not follow at once from the sexual act. I have myself delivered a virgin, though that may seem strange. But if the semen is deposited on the hair of the pubes, that has been quite sufficient for impregnation. If the spermatozoa are alive they can wriggle themselves through an unruptured hymen, where the orifice is so small that it will not admit anything larger than a moderate probe. I have seen a child's head rupture a hymen in a case where connection had never taken place. You know the law regards rape as the act which penetrates into the vagina, but you will see from what I have said that a woman may become pregnant without this act having been committed; the defence would be able to bring forward evidence that the woman was a *virgo intacta*. Of course that would be a rare occurrence, and I do not mean to say that every time semen was deposited on the hair conception would ensue; I simply say it has occurred. You can imagine that if coitus took place immediately after a period it would probably be a longer time before the spermatozoa would reach the ovum than if it took place just before an expected period. In the one case the ovum would have just started, as it were, from the ovary and the Graafian follicles, and would be passing down the Fallopian tube into the uterus. In the other case the ovum would be already in the uterus. Some people imagine that the ovum and the spermatozoa always meet in the Fallopian tube, others say they always meet in the uterine cavity. It is quite certain that sometimes they do meet in the Fallopian tube, because sometimes there is an extra-uterine tubal gestation. It is certain that spermatozoa can work their way along the Fallopian tube into the ovary itself to impregnate the ovum extra-uterine ovarian gestation. It can impregnate the ovum in the peritoneal cavity; it can meet it in the Fallopian tube and set up tubal gestation. It can slip through the fimbriated end, and it may work through the Fallopian tube and rupture, or it may get between the layers of the broad ligament and produce broad ligament gestation. We know it can do all that, but whether the ovum and spermatozoa meet normally in the tube is another matter. Personally, I believe that the ovum travels from the ovary down the tube into the uterine cavity, and waits there for a certain length of time. If the spermatozoa do not arrive there, the ovum goes out in the process of menstruation.

Menstruation is really the parturition of an unimpregnated ovum; it is the laying of an egg. If that is the case you can understand how it comes about that some people say that the very best time for a woman to become pregnant is that coitus should take place just before an expected period. You are often asked that question, and there are all kinds of opinions on the subject. Some think the best time to become pregnant is just after a period is over. The Jews, who are just as prolific as other people, have strict laws on the subject. There are a certain number of days which must elapse after the period is over, and then the woman must take a bath in running water of a certain depth, width and length, after which they are clean and coitus can be renewed. In the East End of London rich Jews provide these baths for the poorer people. In the West End, of course, baths are already provided. And this rule, I think, makes no difference to the child-bearing of the Jews. I believe the best time for a successful coitus is a day or two before an expected period; in fact, when I am asked I advise it a day or two before the aura. You know what I mean by that; the sensations which the woman has before the flow; there are certain feelings in the back and sides a few hours or a couple of days before the flow. You can understand that there may be a meeting of ovum and spermatozoa without any conception taking place, because it does not follow that the ovum will be impregnated. The spermatozoa may be alive and healthy, but the ovum may be dead. We cannot tell by looking at an ovum whether it is alive or dead, as you can in the case of spermatozoa; an ovum has not even amœboid movement when alive, so far as we know. So conception cannot take place unless both ovum and spermatozoa are alive.

There are cases on record where a man and woman have married but had no children. Then they have been divorced, and later each has been re-married, and there have been children born to each. So it looks as if there is a sort of affinity between the ovum and the spermatozoa of certain people. If you try to draw up anything like rules for marriage and conception you will find they do not follow anything like social laws. There are certain social laws whereby a man is not allowed to marry certain people, on the ground of consanguinity, and so forth, but Nature takes absolutely no notice of that. There are certain points about which you can understand I might say a good deal. Some animals will not breed when kept in confinement, but they breed fast enough when they are wild. Wild animals in the Zoological Gardens may have coitus, and yet they may not breed. There seems to be something in the wildness of the life which is necessary for the pregnancy of the animals. Now, if a woman does not have children, the husband, in almost all cases, assumes that it is his wife's fault. Of course if he knew there was something the matter with himself, he would not blame his wife, but mostly he does not know that there is anything wrong with him. According to statistics, the cause of sterility is with the woman in 85 per cent. of the cases. But there are the remaining 15 per cent. to account for. Though the man may be vigorous and appear healthy, and his married life may be all right, yet the reason there are no children may rest with him. In a good many of the 85 per cent. of cases where it is on the woman's side you can get at the cause by investigation. You may not be consulted about these cases when you first go into practice, you will look too young. I see ladies sometimes who say they have come from such and such a place, because, though they like their doctor very well, he is only young and they do not like to mention that sort of thing to him. They tell me they have been married so many years, but have had no children. Later on you may be consulted by the wife, or perhaps by the husband, who will say, "We have no children; what can we do? Now you must remember there is hope in any case of sterility up to three years; almost as good a prospect in the third year as in the first or second. If they have been married two years, tell them you will give them another twelve months. Matthews Duncan's statistics show an enormous falling off after the first three years; after three years the chances become less and less as the years

roll on. If a lady comes to you with such a complaint you will ask her age. Supposing you are asked what is the best age for a woman to marry, you should ask what is she getting married for; is it to have children? If so, the best age is between twenty and twenty-four. If a girl gets married at seventeen she is not so likely to have children as she would if she married at nineteen. Then, of course, if she marries late in life her chances of having children get fewer and fewer.

In a normal condition, with healthy married women, you will find children are generally born about every two years. The woman nurses her child about nine months, then she begins to get poorly again, and then she will fall again. Every two years is better than every year, for parturition every year would weaken her too much, and I think probably her milk would not be good. Then I would ask a lady who consulted me for sterility whether she was an only child. It has been said that heiresses are sterile. It does not matter if she be a heiress or not, if she is an only child it is that which makes her sterile. Ask whether the husband is the only child, because it may be his part which is dying out. In connection with this comes the question of "breeding in." You know that among royalties and the families of peers who will not marry out of their particular circle, this results in sterility. They do not die off straight away; the mother may be one of two in the family, or the only one, and that will tend towards sterility. Some people will say, where there is only one child, that all the energy of the family is concentrated in this one offspring. It is nothing of the kind; there is only one child because the family is dying out, like a tree that bears only one fruit, and then becomes incapable of having any more. A woman might marry when she was forty years of age. If so, her chances of having children are very much less than if she had married at twenty. At forty the woman is approaching the time when her ovaries will cease to act, and the climacteric will come on. Next you should enquire into the relative ages of the husband and wife, as I think that is important. If there is a very young wife and a very old husband, the chances of the girl becoming pregnant are not good. The opposite condition of things—a young husband and an old wife—is not so common. Remember that the change of life in this country is between forty-five and forty-seven years of age, but a man may go on getting children long after that age. A man may beget children at fifty, sixty, seventy years of age, and there are cases on record of even higher ages. A woman may go on having children until she is thirty-six, and then cease, although she continues to menstruate. That may be called the sterility which precedes the climacteric for many years. You may often see ladies of thirty-eight to forty years of age whose youngest child is six to eight years old. The woman may still ovulate, and she and her husband do not know why she has ceased having children. Possibly there is some pathological reason for it, such as salpingitis, etc.

Another important question is that of menstruation. You know a healthy woman ought to menstruate once a month, and she ought to lose a certain amount. If you find on enquiry that the periods are very scanty and painful, and especially if she goes two or three months at a time without seeing anything, that is the usual history of these cases of sterility. On the other hand, you might have a history of profuseness of periods, but there is likely to be some definite cause for that, such as fibroids. That is a bar to conception, and it produces sterility in a way I will mention later. When a woman consults you, therefore, you have to investigate the question of her periods. You may find that she has never menstruated at all; and if you find the cause of that you will have found the cause of her sterility. Where the periods are scanty that generally means that the lining membrane of the uterus is not a good one. You ask the patient whether she has had any serious illness at any time, and particularly about the time of puberty. You may find she had, and that she called it "inflammation of the bowels," but it has really been pelvic peritonitis, and the adhesions have contracted about the fimbriated end of the tube. It is these adhesions formed at that time which have

prevented her conceiving now. You can understand that in such a case the ovum does not get caught by the "devil's bite." You know those tentacles which catch the ovum as it escapes from the Graafian follicles, and they are so certain to catch the ovum that it is known as the "devil's bite." If these tentacles get swollen out and get adhesions about them, there is no catching then, and the ovum drops into the abdominal cavity, and sterility results.

With regard to ovulation, it is necessary to say a few words about that. A woman cannot conceive without ovulating. To have an ovum you must have an ovary. A woman can conceive before she menstruates. In India girls are married quite young, when they are babies, and the husbands are very young too. When the girl is eight or nine years of age the mother watches for any signs of menstruation coming on, and, when she sees these signs, but before the flow, the husband, who may be a boy of eleven or twelve, is sent for, and they must cohabit. If they cohabit before the onset of menstruation, then the girl is not degraded, but she is said to lose caste if she menstruates before marriage. And sometimes she becomes pregnant at once, before she has menstruated. In all hot climates puberty is attained at an early age, just as plants will flower there earlier than in more temperate climes. In such a case as I have spoken of, the first ovum that ripened, instead of being expelled by a menstrual period, is caught by spermatozoa and impregnated, and the child grows. Similarly, I have told you that a woman may conceive during the amenorrhœa of lactation. Then cases have been known where a woman has conceived after the climacteric; ovulation has apparently gone on for a short time after the change of life, though not long afterwards. I have never come across such a case. At all events, it must never be forgotten that ovulation may take place without any menstruation. And the woman may miss one or two periods and then fall, and may calculate from the amenorrhœa, and thus be two months out, which you only find out when you hear the fœtal heart. It is very important to enquire into the condition of the menses in cases of sterility. The normal, healthy menses should be fluid, not clotted; they should be dark and with an odour peculiar to themselves. But if you enquire you will often learn that they are clotted, or they are offensive, or that they look like coffee-grounds, or that they contain membranes. None of these things produce sterility, but if you enquire into the state of the menses that will help you to discover the seat of the mischief. That means that the lining of the uterus, the endometrium, the human nest, is not in a healthy state. When I was sitting on those benches I was taught to apply such things as strong nitric acid to the inside of the uterus. But we now know that that destroys the endometrium so much that perhaps the woman never menstruates again, or only very scantily. You must not employ a remedy which does harm, but in such a case you can dilate up and employ a blunt curette, afterwards employing different reagents, such as iodine, iodized phenol, and so forth, thus setting up a healthy action. Then perhaps the patient will become pregnant. Then you should enquire about discharges, leucorrhœa, "whites," etc. Many women say they have the whites when the discharge is yellow or green. The real "whites" discharge is one made up of the secretion of the vagina, from the cervix, and from the body of the uterus.

At one time it was a disputed point whether the vagina secreted or not. The vagina has a secretion of its own. The mucous lining of the vagina is peculiar histologically as having few, if any, mucous follicles. It secretes from its own surface. It consists of epithelium, a basement membrane, and underneath that there are blood-vessels. Vaginal mucus is largely epithelium; it is clear and viscid, and we know it is from the vagina. Some people say the moisture in it is that which comes from the cervix, but if you do a vaginal hysterectomy you still find the vagina moist. The cervical mucous membrane is rich in follicles, which are studded about everywhere; they burst and there comes away a clear viscid fluid like unboiled white of egg. This may fill the os

uteri with a plug of clear mucus. Then from the interior of the uterus you get mucus. These women tell you that they have a lot of "whites." If the woman tells you the colour of the discharge is yellow you may be able to hit upon the cause of the sterility. A yellow discharge from a woman is not healthy or natural. Often that yellow discharge is due to vaginitis, and the vaginitis is frequently gonorrhœal. You know that gonorrhœal pus, even without the gonococcus, is fatal to spermatozoa. The husband may perhaps confide in you that he knows he has had gonorrhœa, that he knows his wife has it, but that she does not know. I do not propose to tell you to-day how to diagnose between gonorrhœal and other forms of vaginitis; but will simply ask you to find out the kind and proceed to cure it. The unfortunate feature of these cases is that very often the inflammation has spread up through the cervical mucous membrane, into the uterus, and along the tubes, so that you have not only vaginitis, but urethritis, endocervicitis, endometritis, salpingitis, perimetritis, etc., all inside, which, of course, you cannot get at. That is what makes prostitutes sterile. A green discharge is still more inimical to spermatozoa; it is an aggravated stage of the yellow discharge. There may be a watery discharge, and that may mean a vesico-vaginal fistula; or it may be a discharge or growth in the cervix; or from fibroid, or from something in the vagina. A watery discharge washes the semen away, but it may not be so inimical to the life of the spermatozoa as the yellow or green discharge. If there be a recto-vaginal fistula the woman's complaint is not so much of sterility as that the fæces come through the front.

Next you take a note of the general appearance of the patient. Take obesity for instance, a fat woman is not so likely to breed as a thin one. It is not her stoutness which prevents conception; she is fat maybe because her ovaries are not acting properly. The relationship between fat and ovarian activity is one of the greatest possible interest. A fat girl in many cases has but scanty menstruation. I have many ladies consult me when the change of life comes on because they are getting stout; they are anxious to preserve their figures, and accordingly wear tight corsets, but it is no good, they have to leave them off because they are so uncomfortable. You see a lady walking with her daughter; the daughter is slender and the mother "matronly," as it is called, that is stout. The ovaries of the mother have ceased to act, and there is a resulting deposition of fat. Eunuchs are fat for the same reason. Remove the testicles and the man gets fat. A capon s a cock chicken made fat by castration. You may therefore ask whether dieting a stout person who has proved sterile will help her to conceive. I think it would not. Certainly obesity itself is not the cause of sterility, but the ovarian activity is lacking, or the eggs which she is producing are poor in quality, or perhaps few in quantity.

Another point is the general condition of the patient. Note if she is anæmic or plethoric, if she is depressed or melancholy, or if she shows any signs of alcoholism, or of drugging herself with sedatives, for all these things are inimical to conception. Note also her general build, whether she is fully developed or not. Of course you will have an opportunity probably of examining her more fully, but by merely looking at her you can generally tell whether she is well-proportioned and fully developed. When you come to examine her note well her breasts, measure carefully her pelvis, especially between the anterior superior spines, and between the crests of the ilia, which diameters ought to be about ten and eleven inches respectively. When these diameters are nearly alike, and especially when they are diminished, as for example, suppose they were both nine and a half inches, then you have a "flat" pelvis, which is the commonest sort of contracted pelvis. But in a case of this sort (sterility) you are more likely to find an infantile or undeveloped pelvis.

Note also the vulva, the development of the labia, the condition of the mons veneris, hair, fat, etc., also note any cause of dyspareunia, such as urethral caruncle, kraurosis, lupus minimus, sores, venereal and other kinds, enlargement of glands in groins, vulvitis, congenital defects in vulva, vagina, uterus or ovaries,

vaginitis (very common), urethritis, ruptured perineum from a past parturition, stenosis of vagina, or cervix uteri, imperforate and inflamed or sensitive hymen and vaginismus.

In examining the vagina note its length and width and general capacity, also if there be any spasm. The spasmodic contraction of the vagina is due not only to the contractions of the vaginal walls themselves but also to the contractions of the levatores ani and other muscles near the vagina. This spasm is called vaginismus and may be so severe as to cause absolute dyspareunia, and more frequently it causes the immediate expulsion of the semen *post coitum.* The semen may be expelled at once or not for a short time, or perhaps not until the patient gets on her feet. In this last case it is more likely to be a mere flowing out without spasmodic contraction expelling it. Moreover you are not to suppose that even if the semen is expelled immediately that the patient is sure not to become pregnant. Because obviously the vagina could not drive out every drop. Its walls would be at least wet with the semen and therefore would still have on them myriads of spermatozoa.

Any erosion must be noted about the os externum, double vagina, septum, cul de sac, etc. Note if cervix be conical, or if it be deeply cleft. The latter sometimes causes sterility by leaving os internum too patent, so that the ovum easily slips out. Hypertrophies of split portions and chronic endocervicitis, may prevent conception.

Note also any fistulous communications with the bladder, rectum, cysts, abscess cavities, etc. Use a uterine sound and note any difficulty in passing it, as to stenosis. Also the direction, length, tenderness, whether it bleeds easily, and the mobility of the uterus.

Then make a bimanual examination and try to feel if the uterus is in its normal position and if you can feel anything in Douglas's pouch. Very often you find the fundus uteri there (retroflexion) or an ovary prolapsed, or a distended tube, or some lymph from perimetritis, or organised clot from hæmatocele.

Among pathological conditions of the tubes which will prevent conception are—Double salpingitis, simple, gonorrhœal or tubercular. Distension of tubes with watery fluid (hydrosalpinx), pus (pyosalpinx), or blood (hæmatosalpinx). Any bendings, twistings or stenosis or congenital absence of the tubes. Cysts at the fimbriated ends of the tubes and swelling of these fimbriæ themselves often prevent the ovum getting down the tube.

The ovaries may be absent, immature, atrophied, inflamed, degenerated, displaced, or buried in adhesions through inflammation of surrounding parts, or the capsules may be abnormally thick.

It will often be necessary for you to enquire regarding coitus. Very likely you may find there is pain which varies from a mere uncomfortableness to such agony as to prevent any penetration whatsoever. It has happened to me more than once to be consulted on account of the absolute dyspareunia. Another point is excessive coitus. The sterility in such a case is probably due to a weakening of the male element. You will be sometimes astonished to find absolute ignorance in regard to coitus on the part of both husband and wife. Cases have occurred in my own practice which, had they been related to me or if I had merely read about them I should have doubted. I remember a few years ago being consulted by a clergyman and his wife on account of sterility. They had been married five years. On examination I found the lady was a "virgo intacta." She was twenty-seven years of age, her husband was twenty-nine. They said coitus was not painful. On taking the husband aside and asking him a few questions I discovered that he knew nothing at all about the sexual act, and he said he had before marriage always avoided any conversation on such matters, and had imagined that when he got married it would come to him by instinct. And indeed he thought it had come to him and that married life had been going on for the whole five years. When matters were explained to him they went home, and for the first time coitus took place and the lady fell pregnant at once.

Treatment.—What I have already said in discussing the diagnosis will have carried with it to a large extent the line of treatment to be adopted, according to the cause. So that now I can summarise, and at the same time indicate briefly what should be done in different cases.

1. Climate. A warm or hot climate is the best, such as the South of France, Malta, Madeira, Africa, India, etc. Watering places either English or foreign.

2. Food. I cannot enter into full details with regard to food, but speaking generally a spare diet is better, as regards conception, than a too generous one. Moreover, as I have shown elsewhere (Hunterian oration), amongst the poor, hardworking and ill-fed, there is a large preponderance of male over female children, and *vice versâ* amongst the rich and overfed and underworked classes there is a preponderance of female children. You must, however, try to discover whether the patient in her daily food is taking too much or too little of any of the chief foodstuffs, namely, proteids, fats, carbohydrates, salts or water, and advise accordingly. I frequently advise the omission of alcohol in all forms. The general health may be seen to by giving tonics of various kinds. Drugs such as opiates should be given up.

3. Syphilis. Very often you get with syphilis not sterility so much as repeated miscarriages. Still, where a patient has had one early miscarriage which was thought to be due to syphilis in the father, it would be just as well to put both husband and wife on a course of mercury, or maybe iodide of potassium.

4. Vulva. Cure any excoriations, caruncles, pruritis, eczema, etc. Repair any bad rupture of the perineum. Remove hypertrophied nymphæ if so long as to be in the way. Remove any tumours of vulva.

5. Hymen. It may be necessary to cut it or remove portions, especially if it is hypersensitive.

6. Vagina. Cure any vaginitis that is present. Lotio nigra properly used is the best remedy for chronic gonorrhœal vaginitis. But in order to cure it completely it is necessary to apply germicidal lotions, such as nitrate of silver (ten grains to the ounce), on a Playfair probe, along the urethral and cervical canals, where the gonococci find a suitable nidus wherein to develop. If you merely recommend vaginal injections you will find the patient very much better in a week or two, until, in fact, she thinks she is quite cured, but gradually the discharge comes back, until she is as bad as ever. This is due to reinfection of the vagina from the cervical canal or from the urethra, or from both. Any bands, or rings, or cicatrices in the vagina must be cut through in a suitable way. In vaginismus Sims' dilators or bougies may be used, also cocaine pessaries. Where the vagina is too short or too small in its capacity, and whenever there is relative disproportion, you should advise incomplete penetration. Where the vaginal secretions are morbid, for example, too acid, remedy them by suitable reagents. Where the semen comes out post-coitum you can use a cradle pessary.

7. Cervix. Remove portions when it is too long or thickened by hypertrophies of split portions. The cervix may be dilated or split. I generally perform a modification of Sims' operation, in cases of conical cervix, by cutting through the circular fibres twice. In cases of chronic endocervicitis, you may have to scrape it with a sharp spoon or apply a strong caustic. Remove any tumours.

8. Uterus. Passing a sound, or using dilators may be followed by pregnancy. Curetting may be necessary, especially in endometritis. Avoid a sharp curette or you may damage the nest. Apply tr. iodi, or lin. iodi, or phenol, or iodized phenol, according to the strength of caustic required. These are often useful when the menses are foul or clotted, or profuse, or a bad colour, or like coffee-grounds. Some advise the wearing of an intra-uterine stem pessary, but this has practically fallen into disuse. I should, however, try it in some cases, other measures having failed. The use of electricity is at present rather empirical. You might pass a current through with the negative pole in the uterus at one time, and if this failed with the positive pole in the uterus at another; but I have known ladies spend a great deal of money on quack specialists, who buoyed them up with

hopes resting on an imaginary mysterious influence which the application of electricity would bring to bear. Remove any polypi or tumours. Remedy any displacements.

9. Tubes. Obviously it is difficult to remedy sterility due to tube affection. Moreover, such affections are generally bilateral. It is of great importance that gonorrhœa occurring in a woman should be treated and cured as soon as possible, owing to its tendency to creep along the uterine canal into the tubes where it is inaccessible. Prostitutes are sterile usually through this gradual development of double salpingitis with its sequæla, namely, perimetritis round about the fimbriated ends of the tubes, thus spoiling the "devil-bite." Where a double salpingitis, however, has supervened, one can only attend to the general health and cure the gonorrhœa so far as it is accessible, namely, vulva, urethra, vagina, and uterus, and so hope that perhaps the tubes will in the end become so far better as to contain only a sterile fluid, which perhaps will permit an ovum to pass along intact. Beyond this it is a question whether it would be possible to treat the tubes by abdominal section, that is opening the abdomen and, as far as possible, separating any adhesions about the fimbriæ, and perhaps passing a small probe along the canals of the tubes and applying some caustic. Considering the risk to life of this procedure, and the impossibility of promising success in regard to the cure of sterility, it is not likely to be often recommended.

10. Ovaries. Where ovaritis is diagnosed give bromides, apply counter irritation over the ovarian region, such as blisters and tr. iodi. Give hot water vaginal douches. In some cases it may be discussed as to whether an abdominal section might be justifiable for the purpose of remedying any displacement, or freeing an ovary from adhesions, etc.

11. Pelvic inflammations. Hot douches, absorbents, such as hydrarg. and pot. iodidi, given internally. Also rubbing into the skin above the groins a little ung. hydrarg. oleat.

12. Dyspareunia. Remove the cause if possible. With regard to artificial insemination *vide* Sims' uterine surgery.

13. Advise that coitus should take place a few days before an expected period, in fact, a day or so before the *aura*, if any.

14. Finally, let both husband and wife be as natural as possible. I cannot go into every particular, but I will give you one example. A lady was treated by me for some time for sterility, and it was only by mere chance that I discovered that she washed out the vagina daily by means of a syringe, this having been recommended to her as a cleanly habit. She had no notion that it interfered with conception because she only used plain warm water. But as you know, water is deadly to spermatozoa, so that you must find out if the lady is using any syringe and for what cause. If she has a discharge prescribe an appropriate lotion, and when she is cured let her avoid all syringing.

Peritoneal Sensation.

Professor Lennander has published an account of his observations on the sensitiveness of the abdominal viscera and their coverings to the handling they receive during laparotomies.

The work is original and the points raised are temperately and scientifically considered.

He describes an operation thus: $\frac{1}{10}$—$\frac{1}{6}$ of morphia and $\frac{1}{100}$ of strychnine is used previously, the abdomen opened by cocaine infiltration (up to 1½ grains), ether given for pain of packing, etc., rapid intelligent consciousness returns, the operation is done, and finally ether is used for the closing of the incision.

This gives rise to no vomiting or after discomfort, and the patient and the operator prefer this to a continuous general anæsthetic. There is no note of any tendency to struggle, nor of the lapse of time required, and though we should think the mental anguish compensated for the anæsthetic nausea, still we speak here without knowledge.

The results are deeply interesting. The well-known belief in the insensitiveness of the intestines, *e.g.*, for colotomy, is confirmed, and also the extremely sensitive nature of all parietal peritoneum. All dragging on the mesenteric attachment or on any viscus produces acute pain,

nausea, and faintness. Thermal and mechanical, chemical and electric stimuli to the intestines are painless. Cæsarian section revealed the insensitiveness of the uterus.

He ascribes the sensitiveness (p. 25) of the parietal peritoneum to the intercostal nerves in the subserosa.

He finds the liver surface destitute of all sensation, either of pain or touch, and also finds adhesions insensitive.

Three cases are adduced to show that the diseased vermiform appendix and its mesenterolin are insensitive to pain or touch, provided there is no dragging on them, though there was nausea and some vomiting during one operation.

Flushing of the abdomen (Case 17) was painless, as was division, cutting, and blunt dissection of tuberculous adhesions. The fundus uteri, tube, ovary, and round ligament were similarly found to be insensitive to pain, and also the stomach, small intestine, cæcum, and splenic flexures.

Another conclusion is that acutely inflamed intestine is as insensitive as healthy.

One important point not satisfactorily explained is the severe pain of intestinal obstruction.

The pathology of McBurney's point is thus explained: "It represents the spot at which the lymph vessels from the appendix pass on the posterior abdominal wall, that is to say the spot at which the abdominal wall is first involved in a lymphangitis. The serosa then at this point with its numerous cerebrospinal nerves is inflamed."

The pain of a gastric ulcer is not explained except on such similar reasoning.

There is one strange omission that all anæsthetists and surgeons will note, viz., the struggling of the patient and the rigidity of the muscles. This possibly is accounted for by the morphia, but it is the chief objection of most surgeons to any state of anæsthesia except deep anæsthesia, yet it is stated that primary ether narcosis only is employed.

It is a paper of great interest and well worth study. An observation may also be fairly quoted against the paper without impugning for an instant its valuable remarks, viz., that a great number of patients anæsthetised by skilled hands for a normal appendicectomy recover consciousness without any discomfort or nausea within two hours of its commencement, and are saved the occasional twinges "of severe pain" recorded, and also that most anæthetists do not greatly fear the enfeebled condition of a patient, nor heart troubles, holding rightly that if the shock of the operation does not harm them, neither will a properly administered anæsthetic.

Obituary.

Dr. Charles Hathaway.

The death occurred on August 29th, at 11, Edward Road, St. Leonards-on-Sea, of Dr. Charles Hathaway. He was born in 1817, and was educated at King Edward's School at Sherborne, under Dr. Lyons. After some years at St. Thomas's and Guy's Hospital, he went out to India as Assistant-Surgeon in John Company's service. After the Sutlej campaign, in which he was actively employed at the field hospital, he was appointed Civil Surgeon at Lahore. His energies were engaged in the reform of the prisons in the Punjab, and by his exertions the mortality amongst the prisoners was largely reduced, while a saving in the expenditure was effected. During the Mutiny he was on duty at the central goal, where 2,000 long term and life convicts were immured. In 1852, Dr. Hathaway was appointed Inspector-General of Prisons in the Lahore province, and in 1862 the military authorities, on a severe outbreak of cholera amongst the European troops, applied for his services, and the post of "Sanitary Commissioner" was given him by the Government. He was appointed private secretary to the Governor-General of India, Lord Lawrence, in 1863, and finally left the service in 1866.

From the Gazette's Special Pathologist.

NOTICES.

H. A. L., SWANSEA.—This specimen contained a fair number of tubercle bacilli.

T. E. D. H., REIGATE.—This sputum contained a little pus, but no tubercle bacilli were found.

J. M. W. M., ASHTON-UNDER-LYME.—This specimen contained such a large amount of blood that there was relatively little or no sputum present. No tubercle bacilli were found, but it would be advisable to send another sample after hæmoptysis ceases.

PATHOLOGIST.

Passim.

In another column we publish a reply by the writer to the onslaught that Dr. Shaw made on his remarks. We regret that we have been disappointed of an authoritative outline of the probable policy of the London University, the more so as the principal reason appears to be that the authorities themselves are not agreed on their next step. At the same time, while gratifying the natural desire of an aspersed critic to retaliate, we feel that the public interest is not on the abstract question of size of a class, or the superiority of lectures to a demonstration, or the precise date when organic chemistry should be learnt.

The position appears to us to be that there is a widespread feeling of distrust and anxiety among the London graduates lest the Senate of London, in their anxiety to attract students, should detract from the value of their degrees, or in other words, lower the required standard and prestige of a London degree. This feeling has been fostered by the undoubted lessening of the number of obstacles in the Matriculation, by the ready transference of the Organic Chemistry to the Pre. Sci., and by the abolition of a separate examination for the B.S., etc. But the B.S. was embodied in the M.B. after the Cambridge model, for the express purpose of ensuring that the surgery, which was before weak, should be a test of greater merit, it being common knowledge that the standard of surgery required in the M.B. was inadequate.

The studying of Organic Chemistry at the same time as such dissimilar subjects as Anatomy and Physiology has been a source of hardship, especially as the old method frequently resulted in a candidate being rejected as a fresh subject on each occasion. The model arrangement at present would seem to be to keep the student at the scientific subjects till he has passed them all, to allow him to devote his whole time then to Anatomy and Physiology, and on entering the wards to devote at least three years to Medicine, Surgery and Midwifery, which would entail a six years, and as a matter of fact will ever, as it stands, probably always be a six years' course. The London fulfils this in the Preliminary Scientific, practically in the Intermediate, but if it fails anywhere, it is in the cramming of the whole of his clinical work into *two* years, surely a most undesirable relative retrogression in view of the general tendency to increase clinical practice on which be it understood the vast majority of doctors base their professional knowledge.

The real crux is whether the output is to remain the same with a larger entry or whether the same relative percentage is to be maintained and more passed. If the entries are quadrupled will the output of graduates also be quadrupled? If so the standard must fall unless the general average of intelligence should suddenly rise, and if the standard is accommodated to allow a greater number to pass the M.B. will certainly not enjoy its present reputation.

The popularity of the Cambridge course some years ago resulted in a greatly increased number of entries; the authorities allowed no practical increase in the output, so that steadily, automatically almost, the increased competition raised the standard to its present height, with the result that the spectacle of the number who fall out by the way has somewhat diminished its popularity and the entry, but not we believe to the detriment in any way of the school.

The London M.B. formerly offered this certainty, that if the student's *abilities* enabled him to pass the Matriculation and the Pre. Sci., the same abilities steadily exerted would gain him the London M.B. in due course. In other words, the standard of each examination grew gradually easier, and the final M.B. offered less terrors than any of its predecessors. The Conjoint Board conversely offers the hardest trial at the Final, and many a man has found to his cost that the abilities that were equal to the earlier examination, have required prolonged exceptional effort to be equal to the final trial.

The Cambridge M.B. is even more so, the first, second, and third increase in difficulty in

arithmetical proportion, and many men give up between the second and third M.B., whereas in London the bulk of those who pass the Intermediate eventually attain the M.B.

SURVEYING the scheme published in the *B.M.J.*, we are bound to say it seems statesmanlike and sound in its principles but whether under the new constitution the hospital schools will individually continue to flourish we cannot say, but we feel confident that whatever changes the future has in store for us, they cannot affect a reputation that is based on solid endeavour with the aid of sympathetic teachers who enjoy a clinical experience second to none.

THE Royal Army Medical Corps received from Guy's the following, on September 1st, as Probationary Lieutenants—

A. C. H. Gray, 1st	S. L. Pallant, 10th
D. P. Watson, 2nd	A. C. Osburn.
C. H. Robertson, 4th	M. C. Wetherell.
F. M. M. Ommaney, 5th	R. T. Collins.
J. S. Powell, 6th	F. J. Turner.

THE great favour with which the new conditions in the R.A.M.C. are regarded is shown by the fact that from a time "whence the memory of man ran not to the contrary," till the last examination, no man reaching or exceeding the rank and status of a "clinical" had joined the R.A.M.C. under the old régime. That is to say, no one who was placed in the first 24 of his year had been attracted by the Service. With Molière "we have changed all that." Mr. Gray is an M.B., and was House-surgeon and Resident Obstetrician. Mr. Robertson was his successor as House-surgeon and is an M.B. Mr. Watson was a 1st Class Natural Science Tripos, a Cambridge M.A. and M.B., and House-physician. No more is needed to show that the R.A.M.C. has taken of our best, and demonstrate the confidence that the rising generation feels in the new régime. We confidently wish them luck, and are proud of our representatives, to whom we offer our congratulations on their success. Out of seventy-two candidates, we have secured five out of the first six and ten out of thirty places.

MANY Royal Commissions are appointed for the express purpose of postponing decision on burning questions till the force of the movement has died down, and the publication of the unpleasant truth falls idly on unheeding ears. The publication of the names of the Commissioners to enquire into the existence of a lowered standard of physique and into the causes thereof, has not, therefore, attracted so much attention as the importance of the problem demands, because there is some doubt about the sincerity of the Government interest.

IF, however, the serious nature of the enquiry be conceded, it will be granted that it is a subject that those connected with the poor will be most qualified to testify to, and that medical men, particularly those attached to Board School and factories, are in an exceptional position for observing and reading aright the perplexing problem. There is no medical or special expert on the Commission, and such a notable omission almost neutralises the weight of the enquiry.

ANY student at Guy's who passes through his hospital appointments with intelligent observation of his patients, can enunciate definite opinions, right or wrong, on the subject. Firstly, he will be quite clear that the Borough parents are very often undersized, ill-developed, unhealthy, and degenerate specimens of humanity. He would naturally then pass on to the reflection that the poverty with which they start matrimony has been perpetuated by their habits of expensive drinking, and that their physical development after puberty, at which age they often marry, is often arrested and vitiated by bad food, unhealthy surroundings and overwork of all bodily faculties, aided by the results of life-long overcrowding, slum air, and poverty. Further, he will reflect that the multipara may give birth to ten or fifteen children, and every month a mother of twenty and upwards is encountered. Lastly, he will note as an extern, and still more as an H.-P., that the mortality among families is enormous, and that the few survivors of the largest families at some period of their life have been strumous, rachitic, or anæmic.

HIS conclusion will be probably that the Borough factory boy and girl are receiving their full market value and that their wages are insufficient for them to be able to afford the expensive luxury of a healthy existence. In fact it is a social, an economic question, more than a racial one.

BEARING these facts in mind and remembering President Roosevelt's famous remarks anent racial suicide, he will see the fallacy that underlies the frequent appeal to the statistics of population. The birth rate in the Ghetto in the East End is the highest in England, and that in the Borough would rejoice the fatuous figure monger, but to the thoughtful it will inevitably cause the sorrowful reflexion that a high birth rate of Borough children spells ruin to the future generations unless the output of such unfavourable specimens remains controlled by the ravages of infant mortality.

IT is to be hoped the Commission will throw a flood of light on the actual social and economic causes that fill the hospitals with broken down enfeebled workers, and the out-patients with marasmic infants, dyspeptic and weary women, consumptive and bronchitic men, and that the remedies may be indicated as clearly as the disease.

CANCER mortality has a most unpleasant interest for mankind. Heredity plays so strong a part in it in the popular view that it is no exaggeration to say that there are numbers of healthy adults daily tortured with the idea that a death from cancer either as a result of a colotomy in the male, or with the horrible ending of genital cancer in the female, is their inevitable end.

THERE can be little doubt as the result of careful investigation that the mortality is actually on the increase in the United Kingdom. The Report on Cancer in Ireland contains some figures that are worth recalling.

IT must be premised that figures based on post-mortems are not available. In infirmaries there are no reliable statistics, and from hospitals the inoperable cases invariably go home to die. Perhaps the figures of actual death from cancer (with a post-mortem) and their percentages among all deaths (with a post-mortem) will be published soon. The figures here are taken from the diagnosed cancer, not from actual post-mortem evidence, and our own records shew that the percentage of error is a high one.

In 1901 cancer gave a death rate of 6·5 per 10,000 (2893 deaths).

In 1864 a death rate of 2·7 per 10,000.

Briefly, the same is true of England, Scotland, the United States, and most civilized cities.

BAD as this outlook is the mortality abroad is greater. In the last year available it is per 10,000—

Bavaria	10·0	Austria	7·0
Holland	9·3	Prussia	6·1
Norway	9·2	Ireland	6·1
England	8·3	Italy...	5·2
Scotland	8·0	Hungary	3·2

The most fatal age is 60 years and upwards in males, thus—

Up to 40	76	deaths.
40—60	441	„
60—80	679	„

From the point of view of prognosis—

776 died under six months.
873 „ under twelve months.
549 „ under two years.

that is of those recorded only two hundred out of two thousand lived more than two years. It would be most instructive to learn from any future returns how many had been operated unsuccessfully and if possible how many cases had died from other causes. The general impression is that it is in Ireland mainly a disease of decay occurring quite late in life and not running a very rapid course.

WE acknowledge with many thanks the No. 1 copy of the *Guyoscope* which we have received from Dr. Oldman, The Grange, Blechingley, Red Hill.

Change of Address.

Dr. T. Graham Scott has removed from Hebert House to 75, Denmark Hill, and 30, Herne Hill, S.E.

Dr. Frederic G. Vicars has removed from 22, Ovington Gardens, S.W. (travelling).

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Two Cases for Diagnosis.

CASE I.

Charles B., æt. 37, housekeeper. Admitted August 31st, 1903, at 9.15 p.m., for collapse. Family history unimportant. Patient has always been a healthy strong man. For past two months he has been troubled with dyspepsia and has occasionally vomited.

Present illness.—On August 30th at 4 a.m. (41 hours before admission), patient was, whilst in bed, seized with acute abdominal pain which doubled him up; he eructated, but did not vomit. During the day he vomited three times, gradually became weaker and his appetite failed. He had passed nothing per rectum since the evening of August 29th. On August 31st his condition became grave, and he was sent up to the hospital for immediate operation.

Condition on admission.—Temperature, 95·4°; pulse, 140; respiration, 36. Patient is in a state of collapse, his mind is perfectly clear, and he takes quite an interest in his surroundings. He seems to be in no pain and lies on his back with his knees drawn up. Extremities are cold and clammy, features sunken, and his pulse is weak and rapid, but cannot be counted at the wrist with any certainty, the heart-beat being estimated by stethoscope. Abdomen does not move on respiration, it is not distended, but is fairly rigid and slightly tender all over; liver dulness normal. Tongue coated with a dry brown fur. No blue line on gums. Nervous system normal except that knee-jerks cannot be obtained, pupils react normally. Other systems normal. No urine passed.

Progress and treatment.—Patient was given strychnine hypodermically, and a pint of saline solution was infused into axilla; a pint was injected into rectum and retained, and finally an intravenous infusion of two pints of a ·9 per cent. saline solution made with tap water, brought about a slight improvement in his general condition, but an operation was deemed inadvisable at this critical stage. Feeding by the mouth with brandy and other fluid was cautiously proceeded with, but no vomiting ensued. Rectal injections and strychnine were repeated.

September 1st. At 6 a.m. patient suddenly vomited for the first time since admission over the bed about half a pint of green material. Temperature rose to 98°, but the pulse remained feeble and rapid. He remained optimistic, and even bought a morning newspaper at 8 a.m. He gradually weakened, breathing became slightly difficult and more rapid, and he died at 9.15 a.m. rom heart failure, there being practically no lividity—that is twelve hours after admission and fifty-three after the acute onset of the disease. The abdominal condition remained unaltered up to death and nothing was passed per rectum. The patient up to the moment of death was conscious, and he held the funnel of the oxygen apparatus to his face to within a few minutes of death.

CASE 2.

Thomas T., 75, greengrocer. Admitted September 7th, 1903, at 8 a.m., for coma. Family history unimportant. Previous history.—He had his tongue removed for cancer and has had rheumatic gout, but there is no history of syphilis or of swelling of legs or face. He has never been addicted to alcohol and his work is not heavy. He has been treated during the past few years for heart disease. Occasionally he has felt giddy, but has never lost consciousness or power.

Present illness.—Patient was going to his work as usual, when, without warning he lost consciousness at 7.30 a.m. and fell to the ground, grazing the right side of his head. He did not give any cry and was not convulsed, according to the statement of his friends. He was at once brought to the hospital.

Condition on admission.—Pulse 46. Temperature 95°. Respiration 26. Patient cannot be roused. Breathing in character is "Cheyne-Stokes." Breath rather sweet in odour, but no alcoholic smell. Eyes turned to left side; pupils fairly small, equal and react to light; conjunctival reflex present, discs rather blurred, otherwise normal. Right arm seems more rigid than left. Right knee-jerk not obtained, left just perceptible. Other reflexes normal. Pulse is paradoxical, low tension, slightly slapping and of full volume; radial artery thickened. Heart signs obscured by emphysematous lungs; a to-and-fro bruit faintly heard in the third left space close to sternum, and a localised systolic bruit heard in mitral area. Urine, 1018, acid, albumen two parts per 1,000, no sugar, blood, pus or diacetic acid, urea six grs. per ounce.

Progress and treatment.—Croton oil (m 2) on butter was given and in about two hours patient became conscious. Later on he could talk quite rationally, but his speech was slow, blurred and indistinct (his tongue had been excised). There were no delusions, his memory was good and as far as could be ascertained his mental condition seemed normal, except that cerebration seemed slow. Power in right leg was found to be less than in left. During the day he passed altogether one pint of urine; he took milk well, but vomited once in the afternoon. At 7 p.m. he turned on to his side and was dead. His temperature never rose higher than 97·6° and his pulse remained the same, varying between 40 and 46 per minute.

For Solutions see page 380.

Appointments.

SANDOE, J. W., M.D. Durh., has been appointed Certifying Surgeon under the Factory Act for the Silverton District of the County of Devon.

SECRETAN, W. B., M.B. Lond., F.R.C.S., has been appointed House Surgeon to the Royal Berks Hospital, Reading.

Hypnotism: Its Therapeutic Value.

A Paper read before the Physical Society by P. R. BOLUS.

"Stop! let me have the truth of that."

GENTLEMEN,—I propose to bring before you to-night a birdseye view of the more important observations in a science which some consider to be the most valuable of modern achievements: a science interesting in itself and still more interesting in its possible application to psychology, to education and to therapeutics: a study ancient yet very modern: a group of phenomena rational yet for ever mystic.

First, then, we will consider the nature of Hypnosis, its symptoms and the theories formed to explain them. After this we will investigate its use in therapeutics and the methods of its employment by medical men.

In dealing with hypnosis as an entity, I shall follow largely the classification and arrangement of Moll (of Berlin). The history of hypnotism as a science may be dated from the time of Mesmer (1734–1815), who frequently induced a state of hypnosis, which he ascribed to various causes. In his early life the planets were the efficient agents, while later, metallic magnetism, animal magnetism and contact formed in turn his working theories.

In 1784, Chastenet discovered "artificial somnambulism" a state in which the subject is asleep and his ideas and actions are regulated by another. Wolfast, in 1812, introduced "magnetism" into hospital treatment, and gave lectures on the subject to the students of Berlin. About this time the whole subject fell into disrepute, due partly to its admixture with error, partly to ignorance, and partly to the stress laid on the mystical as apart from the scientific and critical aspect of the study. Faria (1815), showed that no known force is necessary for hypnosis, and maintained that the cause of the sleep is in the patient, subjective. Braid (1848) introduced the term hypnotism, and evolved the theory of a double consciousness to explain its action. Forsaking the physical methods of inducing the trance, he obtained sleep by concentrating the mind on a point and by verbal suggestion.

The school of Nancy, with Liébeault as its founder (1866), and Bernheim as his first proselyte (1884) aroused world-wide interest in its work. Their theory may be summed up in the words "hypnotism is suggestion." The rival school of the Salpêtriere (Paris) has had, I think, less influence than that of Nancy.

Since 1889, when Moll published an excellent treatise on the subject, the number of workers has been legion, and their seat the four corners of the earth. A few master workers of modern times will be referred to when we deal with the therapeutic uses of hypnosis.

The following experiments are presented as types of the hypnotic state.

Experiment I.—I tell the subject to sit down and look at a button (the nature of the object is indifferent, concentration essential). In three minutes his eyelids droop, his eyes quiver. Soon they close and remain in this state. I say, "You cannot open your eyes." He makes ineffectual efforts to do so. I say, "You cannot raise your hand." He raises his hand, however. I then blow on his eyes and he resumes the waking state.

In this experiment you will notice that there is no loss of consciousness or of memory. There is no physical change except (perhaps) fatigue and loss of power to open the eyes.

Experiment II.—I am seated opposite the subject and continuously for ten minutes make slow monotonous passes in front of her. These movements consist in passing the hands with palms foremost, and about one inch from the subject downwards from the vertex to the epigastric region, the hands being then swept round to the vertex again. By this time the subject's eyes are closed, she breathes deeply and feels lethargic. I lift her hand; it remains raised and drops again on command. I tell her she is dumb: she makes ineffectual attempts to speak, the lips moving but making no sound. I then tell her she can speak, she immediately speaks normally. I say to her "You hear music;" she shakes her head in negation. I then wake her by passes upward with the backs of the hands toward the subject.

In this experiment you will notice that the eyes are closed and movements become impossible when forbidden.

Experiment III.—(Subject has been hypnotized several times before). I ask him to look me straight in the eyes. Then, keeping my eyes fixed on his I take his hand and draw him along with me. I raise my right arm; he does the same. I motion to him to kneel down; he kneels and cannot rise till I remove my gaze, when the charm is broken.

Here patient makes movements of imitation with his eyes open and fixed on mine.

Experiment IV.—The subject being seated, I talk to him as follows, pausing between each sentence. "Try to sleep.—Think of nothing except that you are to sleep.—Now you are more tired.—Your arms go to sleep.—A feeling of heaviness comes over you.—Your thoughts grow more and more confused.—Now you can no longer resist.—Sleep (eyelids close)." I raise his arm; it remains up. I ask him, "Are you asleep?" He replies, "Yes." "Do you hear the music?" He replies "Yes," and perhaps remarks on its beauty. I put a black cloth in his hand and say, "You feel the dog." "Certainly." I drop the cloth and he stoops and strokes it. The subject will not obey orders given by other people present. He is *en rapport* with me and with me only. I call "Awake," and he wakes, remembering only going to sleep and having no recollection of the events which occurred during hypnosis.

In all these experiments the state induced is hypnosis. In all these cases some voluntary movements are inhibited, and in all four instances conversation is possible. Hallucinations occur in the last experiment. Many

classifications of the degrees of hypnosis have been made, but none of them are quite satisfactory, and the only one which seems to me of practical use is that of Dessoir, who divides hypnosis into two stages. In stage I. the voluntary movements show changes, centrifugal nerves only being affected, while in stage II. abnormalities of sense functions are superadded showing that centripetal nerves are also involved. A moderately skilful hypnotist can, perhaps, cause such changes in 75 per cent. of people, but of these probably the second stage will be reached by only 20 per cent.

Normal sleep may be changed into hypnotic sleep, but this is rare. I have, however, known one well marked case. The subject is a young man, and I have frequently hypnotised him when asleep, carried on long conversations with him, transported him to various places while still in bed, and finally restored normal rest by ordering him to go to sleep. On awaking he has no memory of my machinations.

It is seldom possible to hypnotise a man against his will. Concerning the susceptibility of various people to hypnotic influence I shall speak later. The methods of inducing hypnosis are many; but the mental processes are largely ousting the physical agencies. Thus, one may concentrate the subject's attention on a point (Braid), as in Experiment I., or one raises the image of hypnosis in the mind of the patient, as in Experiment IV. (Liégeois). Physical methods include stimuli of sight, hearing, muscular sense and touch (taste and smell give negative results). We have as classical examples the magic drum of the Lapps, and the whirling dances of Fakirs. The so-called omphalopsychics induce a trance by gazing at the umbilicus. Sometimes sudden strong stimuli are used, but an unexpected strong light or loud noise is more likely to cause paralysis from fright than hypnosis. The animated windmill style of Experiment II. seems to be generally efficient in the hands of experienced workers.

We will now digress, again following Moll, to discuss briefly the phenomena of suggestion and increased suggestibility. Every concept has an action on the individual recognizable by certain internal and external effects. For example, the idea of the Externs' room awakes the idea of beetles. A concept may also arouse feeling. Thus, the idea of the Extern's room arouses grief or a desire to destroy the game. Again, many people feel nausea directly beetles are spoken of. Lastly, a concept may also have an effect which displays itself externally, perhaps by a movement. We find an instance of this in the involuntary movement of the lips when one thinks intensely of a word; and the same law explains the erstwhile fashionable game of thought-reading.

Now, in many cases definite effects of this kind can be induced by the "suggestion" of ideas by others. A good instance is that of the juggler who persuades his entire audience to gaze at his left hand and ignore the rabbit in his right hand, although it is within their view. Another common example is found in blushing. Say to a lady, "Now you are getting red in the face," and often enough the suggestion takes effect, just as we saw suggestions to be successful in the Nancy method of inducing hypnosi Auto-suggestion is also known; many a boy will stammer when he thinks of stammering, although nothing is further from his desire. Many hysterical paralyses, especially those giving a history of trauma belong to this class. I remember some fifteen months ago, a girl was brought into the front surgery suffering from what we cleverly term hystero-epilepsy. The girl, who had previously been complaining of her head, was lifted by her shoulders and legs on to a couch. She then complained of stiffness and pain in the left leg. This patient held the left knee extended against such a force as would undoubtedly have flexed it if she had been in her normal condition. She was anxious to leave the hospital, and on being allowed to go she flexed the knee with the utmost ease. This case I should regard as one of auto-suggestion.

An exaggerated disposition to react to suggestion is called suggestibility and this is the mechanism of many hypnotic effects.

The *symptoms* of hypnosis will next engage our attention.

1. The activity of voluntary muscle can nearly always be influenced in a high degree. The statement, "You cannot raise your arm" suffices to make it impossible. The loss of power may be due to inability to contract certain muscles, or sometimes to the contraction of antagonistic muscles which prevent the movement. Paralyses may be caused similar to many neuroses, with loss of motor power, muscular sense and sensation; increase of tendon jerks, ankle clonus, changed electrical excitability and vasomotor change evidenced by flushing on slight stimulation (Richer).

Imitative movements may occur even without the subject seeing the movement of his temporary master. There is a strong inclination to maintain cataleptic positions, as is seen in some cases of typhus fever and hysteria. Heidenhain goes so far as to say that hypnosis is artificially produced catalepsy. Some functional abnormality of voluntary muscle always accompanies hypnosis. According to Charcot there is often neuro-muscular hyperexcitability so that, for instance, pressure on the ulnar nerve will cause a typical contraction of the hand muscles. Moll's view is that all muscular changes are due to suggestion.

2. Senses:—We have seen that illusions and hallucinations may occur. A subject is given a cork with the assurance that it is an onion. His eyes water, and to him for the time it is an onion.

Loss of appetite or a sense of repletion can (rarely) be caused. All kinds of pain may be awakened by suggestion. Analgesia will be dealt with later.

3. Involuntary muscle:—Respiration and circulation show no changes in hypnosis without suggestion, save those of prolonged attention or of sleep. The pulse curve is unaltered (Horsley). In a few cases the respiratory act can be inhibited by suggestion—in one case for three minutes.

If the subject be told that his bowels will act at a certain time, this will occur, although he may not have any recollection of the suggestion.

4. Pathological changes: — Such may be induced by suggestion during hypnosis. Menorrhagia may be caused or arrested in some cases (Briand). In this hospital a blister has been caused by placing a blade gently on a woman's arm and suggesting that it was red hot. Epistaxis and purpura have been produced. Forel, in the presence of several witnesses performed the following experiment on a nurse twenty-three years old:—A small cross was made by a blunt instrument on each arm. It was suggested that a blister should rise on the right arm. At the end of five minutes a papular swelling like nettle-rash was seen around the cross on the right arm, while the similar cross on the left arm remained unchanged.

5. Memory may be inhibited or sharpened. It is not unusual for subjects during hypnosis to remember all the proceedings of former hypnoses although when awake they have no recollection of any of these things.

Almost all kinds of aphasia may be caused by suggestion. Moll told a lady of thirty-four that she was a child of eight. She then played with her doll and spoke childishly. She also wrote in an infantile manner and made many orthographic mistakes.

Many suggestions made during the hypnotic sleep are obeyed long after awaking. A subject was told on May 3rd: "On June 6th you will come here, see me with a black face and laugh." This was done though the subject had no recollection of the command.

6. The will is not entirely absent in hypnosis, but the centrifugal channel is blocked. Sometimes the subject has a keen desire to be awakened.

Such are, in summary, the commonest symptoms of hypnosis. No two cases are alike in detail, just as no two minds resemble each other entirely.

We now have to compare hypnosis with several cognate states which sundry scientists have considered identical with it. The resemblances and differences between hypnosis and sleep are outlined in the following table:—

EARLY STAGES OF SLEEP.	LIGHT HYPNOSIS.
Drowsiness.	Drowsiness.
Fatigue.	Fatigue not uncommon.
Marked decrease of self-consciousness.	Self-consciousness intact.
Memory impaired.	Memory unaffected.
Heaviness in limbs but all voluntary movements possible.	Loss of voluntary movement.
Tendency of ideas to occur apart from will.	No tendency for current of ideas apart from will.
SLEEP.	DEEP HYPNOSIS.
Dreams arising from stimulation of nerves or association of ideas.	Sense delusions of same kind as in sleep, differing only quantitatively if at all from dreams.
Movements, either continued (rider still clutches reins when asleep) or suggested (sleeper pulls up clothes when they are displaced.	Movements of same kind as in sleep, differing only quantitatively.
After effects of dreams.	Post-hypnotic effects.

From this it is seen that the two conditions have much in common. With regard to the causation of dreams, I would give instances showing their origin. A little water thrown on the sleeper's head often causes dreams of a thunderstorm. Voltaire wrote poetry during sleep. One frequently dreams of the horrors of examination after an evening's reading.

Hypnosis has also been compared with mental disorder artificially produced. Insanity, however, cannot be cured by the command to wake, neither is the madman *en rapport* with any other being.

The comparison of hypnosis with hysteria or neurosis seems to me an unprofitable juggling with unknowns.

Catalepsy, lethargy, intoxication with alcohol, chloroform, opium or cannabis indica fail to conform to the two great features of hypnosis:—

1. Increased suggestibility.
2. Power of ending the state at pleasure.

Experiments on animals show interesting analogies to those on man but do not assist our scientific criticism.

If a hen be gently placed on the ground so that its beak touches the earth and a chalk line is then drawn from its beak forward, the bird will remain passively in this position for a very long time (I have seen the trance last for four hours). The fowl resumes its routine life when moved.

A frog in the same way will stay inert in a fixed position if held there for some minutes and then left. Sometimes the cutaneous reflexes of the leg are lost.

In Austria the "fascination" method of hypnotizing is used by law for shoeing horses.

The paralysis of birds by snakes, rabbits by stoats, and the work of wild beast tamers may be of the same nature. With regard to the action of stoats on rabbits, I recently read a paper by some ultra scientific person who maintained that the stoat never paralyses its prey but attains its end by darting on Brer rabbit as the latter runs along a burrow which crosses the end of that in which the stoat lies waiting. I was therefore highly pleased when, coasting down a Devonshire lane I saw on the road in front of me a stoat facing a rabbit. As I approached, the stoat made his escape while the rabbit remained rooted to the spot and lay still when I took it up in my hand. There was no sign of injury on the rabbit and it was able to run off an hour later.

The difficulty of making deductions from experiments on the lower world is obvious: as Huxley once said, "No one who has not himself been a frog can make any assertion concerning the frog's consciousness."

Let us now review the theories formulated to explain hypnosis. Explanation, in the sense of tracing

phenomena back to what we know, is impossible, since we know nothing of the nature of our mental processes.

By Moll, Bramwell, and many others hypnosis is looked upon as an exaggeration of certain normalities. We shall understand this more clearly if we bear in mind two laws of ordinary life. First, that the tendency of man's mind is towards credulity and influence by others, and secondly that many psychological and physiological effects tend to appear if a person is expecting them. The belief in monsters, triplets, and so forth by people who have never seen them, illustrates the first point, as also does man's gregarious habits. Examples of the second law are sufficiently common. We all know the terrible pain felt by the patient in the front surgery just before the beneficent Sime has touched her. We have all performed cures by the administration of Aq. Destil. ʒj. t.d.s. Suggestibility, then, is a normal occurrence, and the muscular effects of hypnotism are merely exaggerations of this. Probably one reason for their being so marked is that, after the first effect (Experiment 1) the subject doubts the strength of his own will and so the operator's power is increased.

Sense delusions, like those of hypnotism, we can hardly find in normal waking life but dream-consciousness is very similar.

Rapport is nothing more than influence, and is no new psychical observation. The memory effects are explained by the double consciousness admitted by many writers on psychology as normal.

In such a way as I have just outlined the mysticism of the subject is shifted to the background. Yet somehow the theory lacks conviction, surely the mysticism still looms on the horizon.

An alternative theory is provided by Richet. Hypnosis is regarded as the loss of a certain mental inhibition, the omission of one of the elements of judgment, so that the subject can no longer voluntarily make a concept ineffectual. If the basis of hypnosis be of this type we should expect a shorter reaction time than in the normal state. (By reaction time I mean the interval between the application of a sense stimulus and the external sign caused by it.) Stephen Hall finds this difference well marked and gives the following figures:—Normal, ·328 sec.; hypnosis, ·193 sec. Other unsympathetic observers have obtained an opposite result.

Among physiological theories we notice one of Heidenhain's, which maintains that hypnosis means inhibition of the ganglion cells of the cortex induced by continuous weak stimulation. In this, as in many other absurd hypotheses, much is asserted, little proved. It seems probable that the nature of hypnosis will remain open for many years as a happy hunting ground for guessers after truth.

As a therapeutic agent hypnosis has been used from the time of Mesmer.

John Elliotson, a giant of his time, was the first English physician (as Bramwell points out) to use mesmeric treatment extensively (1837). He resigned his appointment at University College in protest against his colleagues' condemnation of the method.

James Esdaile, a surgeon employed by the Government in India, reported in 1851 that he had performed 261 painless capital operations and many thousands of minor ones under hypnotic influence. He reduced the mortality in the removal of the enormous tumours of elephantiasis from 50 to 5 per cent.

Braid, a Manchester surgeon, stands as the next landmark. He purged the mesmeric science of many errors, invented the term hypnotism, and laid the foundation of the most modern views regarding hypnosis. Braid treated successfully many cases of hysteria, epilepsy, neuralgia, chorea, dipsomania, constipation, etc. He also caused improvement in some paralyses of organic origin. Braid died in 1860, and since that time very little of value has been added to the science of hypnotism.

Of quite recent authorities, Liébeault, Bernheim, Forel and Wetterstrand are the most prominent.

Hypnotism, apart from sentimental objections, is not altogether free from danger as a method of treatment. It happens very rarely that difficulty is experienced in bring the patient round. Also the great susceptibility of a person who has been hypnotised many times is not an enviable state. Lastly, the remedy would become extremely dangerous in the hands of the unscrupulous or thoughtless. It is certain that subjects may sometimes be induced to commit crimes during hypnosis. Suicide and theft may occasionally be effected by suggestion, and Liegeois made a girl fire a loaded revolver at the imaginary presentment of her mother during hypnosis. Certainly most subjects would refuse to do such things. The method, therefore, like all really effective modes of treatment, is not entirely free from risk.

We must also consider the applicability of hypnosis. Who can be hypnotized? Dr. Wetterstrand found that out of 6500 people on whom he attempted the process, only three per cent. remained uninfluenced. For many cures, however, a well marked degree of hypnosis is necessary. Delbœuf influenced over eighty per cent. of the people whom he tried. As in every mental process, individuality plays a very important part. Contrary to general opinion, weakness of will, bad health, and impulsive character do not predispose, but rather render hypnosis unusually difficult. The desirable point seems to be the ability to give the thoughts a certain prescribed direction. This may be due to natural capacity, to habit (soldiers are good subjects), or to strength of will. Sex has no influence. Children under eight years, hysterical, stupid, and insane people are difficult to affect. According to Bernheim, tuberculous patients are very susceptible.

Now, the use of hypnosis arises from the premiss that a number of diseases can be relieved simply by making the patient believe that he will soon be better. Thus, suggestion alone is very useful in treatment, as is well seen in the miraculous cures at Lourdes and other places. It frequently happens, however, that the patient will not accept your assurance that he will get better. Hypnotism

affords the means of implanting the idea of cure in his mind.

The chief field for treatment lies in the functional neurosis (as distinct from hysteria with its numerous and variable symptoms and its peculiar personality).

According to Forel, treatment by hypnosis is indicated in the following conditions:—

Pains with no anatomical cause (whether gastric, headache, ovarian, rheumatic or neuralgic), sleeplessness, functional paralysis, disturbances of menstruation, alcoholism, morphinism, stammering, loss of appetite, singing in the ears, some disorders of sight, prolonged chorea, railway spine, emotional neuroses, agoraphobia and writers' cramp of central origin. A cure is often obtained when cold water treatment, massage, operation and drugs have failed to relieve the symptoms.

Among disorders with an organic cause which have been alleviated or cured are the following. The pains of tabes dorsalis (the cord lesions were seen post-mortem), the pains of articular rheumatism, with marked swelling of the joints; apoplectic paralysis (causative lesion found at the autopsy), and the agony of a severe painful eczema. In the last case the patient could afterwards bear hard pressure on a surface which had formerly been acutely painful when touched. Epilepsy is said to have been cured by repeated sittings (Wetterstrand), but in a case of epilepsy reported as cured by Mason (of New York), the diagnosis from hysteria is not made clear.

The usual method used is to induce the deep sleep and state that the desired effect will occur. Treatment lasts for only a few minutes at the first application.

I would like to read you a pen picture by Bramwell of Liébeault's routine work (*Clinical Journal*, May, 1902)—

"I found Liébeault's clinique invariably thronged, but there was neither excitement nor air of mystery, and everything was conducted in simple homely fashion. The patients chatted freely amongst themselves, and questioned the doctor in a more familiar way than one had been accustomed to see in England. Each in turn was placed in an armchair, told to think of nothing, and to look steadily at the operator. The fixation was not maintained long enough to produce any fatigue of the eyes and appeared to be simply an artifice for arresting attention. If the eyes did not close spontaneously, Liébeault requested the patient to shut them, and then proceeded to make the following suggestions or others resembling them:—'Your eyelids are getting heavy, your limbs feel numb, you are becoming more and more drowsy, etc.' A certain proportion of the patients apparently passed into a deep hypnotic trance; others only became restful or drowsy. In each instance, curative suggestions suited to the individual case were repeated for about ten minutes. The patients were then told to awake, when they either walked quietly away or sat for a little to chat with their friends. Liébeault took especial pains to explain that he neither exercised nor possessed any mysterious power, and that all he did was simple and capable of scientific explanation. No drugs were given."

The value of hypnosis in the oars obstetrica is problematical It is reported that some women have been sent to sleep during labour without affecting the uterine contractions.

The surgical application of hypnosis concerns its power as an anæsthetic. Partial analgesia is frequently induced: the patient may feel no pain on pricking with needles, yet the faradic brush causes reaction. The reaction to ammonia in the nostrils and to tickling the throat may be lost. Complete anæsthesia sometimes occurs, but is rare according to Moll. Minor operations have been performed in this hospital without pain under hypnotic influence. Bramwell has obtained very satisfactory results in this country. I quote one of his cases which was performed in the presence of Pridgin Teale, Mayo Robson and many other medicine men. "A delicate girl was put to sleep by written order while I remained in another room, and sixteen teeth were extracted. She showed no signs of pain, there was no corneal reflex, and the pulse fell during the operation." A rapid and painless recovery usually ensued in Bramwell's cases. Hypnosis, then, is frequently useful as an anæsthetic, but seems unlikely to oust its powerful rivals. In cases of valvular lesions of the heart the employment of hypnotism for this purpose appears desirable.

Concluding, gentlemen, I thank you for your attention to this paper, and I would remark that you will find the subject when dealt with in detail full of interest and instruction.

Correspondence.

To the Editor of Guy's Hospital Gazette.

The London M.B. Examination.

Dear Mr. Editor,—I was much interested to read Dr. Shaw's annotations in your last issue on my remarks on the London University. It was specially interesting to me to see how a clear, not to say brilliant thinker could yet hide from himself the true aspect of affairs while accusing me of a misstatement of facts.

Dr. Shaw assumes, quite unjustifiably, as I shall show, that the larger the school, the larger the classes. I am prepared to admit, indeed I have never denied, that the association of a man with a large number of his fellows tends always to an increase in his education. But I will not admit that a student is better instructed when he is one of a class of sixty than when he is one of six. Every student of chemistry will bear witness to the futility of the artificially stocked chemistry lecture, and the real value of the small demonstration where the teacher addresses his audience individually as well as collectively. The medical school here certainly

has a large entry of students and a proportionately large attendance at lectures, but it owes its success, not to the crowded theatre but to the handful in the class-room.

It is hardly worth while answering Dr. Shaw's suggestions that the private tutorial and correspondence places should show the best results if my contentions were true. In making a coat one requires both the cloth and the knowledge how to cut that cloth. It is not generally conceded that either the teachers or the taught in the case of the advertising tutorials are of the highest or even of medium quality.

In claiming for the University a desire to eliminate cramming Dr. Shaw is but demanding its due. I do not deny the desire, I simply hold that the method of satisfying the desire is futile. The modification which I considered Gilbertian, and which Dr. Shaw considers will "still further eliminate cramming as a profitable employment for medical undergraduates," was the inclusion of the Inter. M.B. chemistry, with syllabus practically unchanged, with the subjects of the Prel. Sci. Most men found two years none too long to get hold of the subject when they had acquired a sound grasp of inorganic chemistry. They are now asked to absorb the same amount in half the time, and without any previous ground work in the inorganic section. This change, characterised by me as Gilbertian, is considered by Dr. Shaw to "still further eliminate cramming, etc."

The conclusion of Dr. Shaw's remarks, in which he reveals the reason for his letter, I would most heartily endorse. By all means come to Guy's for your medical education. But don't come because you consider the classes are large. Come because of the high efficiency of the small demonstrations, and the personal interest of the teachers.—Yours, etc.,

THE WRITER OF THE ARTICLE.

Sport.

Guy's Hospital Lawn Tennis Club.

The match team has during the past season met with but average success, six matches having been won and six lost, the best performance being against Blackheath A, whom we beat by 5 to 3. Messrs. Lucas and Palmer have won most of their games, playing as first pair; while Messrs. Earle and Zorab have made a strong second pair, but our third pair, though many combinations have been tried, have only succeeded in placing one game to their credit throughout the season.

The Championship Cup was won for the third year in succession by Mr. T. C. Lucas, he having beaten Mr. F. W. M. Palmer, the "runner up" by 6–1, 6–2, 6–1. Mr. T. C. Lucas also won the Handicap Singles at owe $15\frac{4}{6}$, having beaten Mr. A. Zorab (owe $15\frac{3}{6}$) in the final by three sets to one.

In the Inter-hospital Cup we were badly beaten by London, though Messrs. Lucas and Palmer won their singles. The Cup was eventually won by St. George's.

A team was raised for the Junior Inter-hospital Cup, but it was won by St. Thomas's.

Solution of Cases for Diagnosis.

POST-MORTEM APPEARANCES.

CASE 1.

The diagnosis was perforated gastric ulcer and peritonitis.

P.-M.—Omentum—shows fat necrosis. Peritoneum—not inflamed, but that covering stomach, duodenum and jejunum is rough and has a mottled appearance as though partially digested. Pancreas—enlarged, firm and hard; on section shows curious white mottling, but no pus or hæmorrhages in its substance; around the pancreas there is a little recent hæmorrhage into the tissues, which appear necrotic. Other viscera normal.

Result—Acute hæmorrhagic pancreatitis.

CASE 2.

The diagnosis inclined to cerebral hæmorrhages, embolism or thrombosis.

P.-M.—Aorta—atheromatous. Lungs—emphysematous. Heart—hypertrophied, left ventricular wall over one inch thick; aortic valves are atheromatous and shrunken; mitral valves thickened and slightly shrunken. Kidneys—congested, normal size and in a very early stage of granular kidney; arteries to kidneys are atheromatous. Brain—meninges over convolutions greatly thickened, and the dura mater is partly calcified; convolutions seem slightly shrunken. No evidence of any hæmorrhage, embolus, or thrombus.

Result not absolutely sure: either anæmic or syphilitic meningitis.

K. B.

Birth.

WAINEWRIGHT.—On August 25th, at the Cottage, Cliff Avenue, Cromer, the wife of Robert S. Wainewright, M.D. Lond., of a son.

Marriages.

GREEN—GILBERT.—On September 4th, at St. James's Church, Knatchbull Road, S.E., by the Rev. J. D. Dyke, M.A., Vicar of the Parish, Albert Green, M.B. Lond., of Chesterfield, Derbyshire, to Gertrude Annesley, second daughter of William Gilbert, of Cormont Road, S.E.

LE FEUVRE—WESTERTON.—On September 8th, at St. John's Church, Bulawayo, by the Venerable Archdeacon Beaven, William Philip Le Feuvre, of Bulawayo, eldest son of Edmond Philip Le Feuvre, of Blackheath, to Florence, second daughter of Charles Edward Westerton, of Rondebosch, Cape Town.

ED.—J. M. B.

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Notice.

All Communications, Articles, Letters, Notices, and Books or Review should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, SECRETARY'S OFFICE, GUY'S HOSPITAL.

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING AND SIXPENCE.

Guy's Hospital Gazette,

SEPTEMBER 26, 1903.

A Lay Sermon.

IT would be a joyous thing if one were enabled by some occult process to limit the reading of these lines to the few for whom they are intended. The knowledge that they must stand the scrutiny of the veteran, the blasé and the chronic, to each of whom life appears in a different hue, acts as a most powerful drag on the instructive pen, a veritable Bowden on the free-wheel of thought. It is to the boys that we would speak, to the real, fresh, new boys who are yet aglow with the hot enthusiasm of youth. You who crowd the dissecting-room, smoking fiercely that the taste of tobacco may blur the biting novelty of the scene; you who throng the lecture theatres with the blameless note-books and the earnest crayons; you who move in flocks from spot to spot that your very numbers may give you courage; it is to you and to you alone that we would speak. Be of good heart, for you are our future and in your hands lies our good name.

We who call ourselves Guy's men now will shortly pass into the realm of the Past, and the fate of our name, be it good or bad, will lie in your keeping. Therefore, it is but just that we should offer, with infinite humility, some few scraps of advice that may help—such is our overweening vanity—in the preservation of our fame. For whatever may happen to the School, whatever may happen to London University or the Conjoint Board or other creation of a night, Guy's will remain Guy's, and we of her!

There is much in front of you; much before you reach the half-way house of your schooling, still more when you have entered the wards. There are posts—student appointments they are called—in which you may shine to your own satisfaction; also, if you be true, to the satisfaction of others, and you may quit your holding with a heavier roll of friends than when you entered it. But, and the "but" is big with many forebodings, you may find yourself with powers over others before you have yet gained power over yourself, and you may reap for yourself but the jibes and hatred of your fellows. This much lies within you. Remember only that you are but for one term, and that term is but one of a year. There have been many before you; doubtless there will be many after you in the like position. So cherish it only for its worth, and relax not your watch on yourself.

We have met some, who even in the days of the dissecting-room, gave evidence of the true hearts that lay within them, and some who shewed in a like period the burnt clay beneath the bronze. To the one has accrued the lasting palm of repute among his fellows; to the other an ever-increasing and more powerful contempt. For you will not gain respect by your intemperate conduct; fear maybe, in the early days, but when your fangs have lost their sting, contempt and odium. Later, and with more wisdom, you will cross the road and enter the true gates of the hospital. Till now you have been but a hanger-

on, working under compulsion for your own good, now you become in truth a Guy's man, and learn in voluntary service to others the only real lessons of your profession. It is inevitable that in this stage of your life you should be most prone to error. It is the very curse of your existence, and demands the keenest and most searching introspection. Once assume the pleasing robe of self-complacency, and you are doomed, fearfully and irretrievably doomed, to a life of ineptitude and mediocrity. Strive to learn by others, by their successes and their failures, but above all, strive to learn by yourself. Do not be too ready with criticism on things which you fail to appreciate; do not consider utility and intelligibility as synonyms. There must be some who can see further ahead than the ruck, else would the ship of life run high on the sands of ignorance.

In time, doubtless, a goodly number of you will set up at the high-table in the hall, where you will taste the sweets of complete and unopposed power. A goodly number of you will reach this lofty and exalted position; a goodly number have already preceded you, therefore be not puffed up with pride at the contemplation. When the extent of your power first sweeps over you, there will be even greater need for the calm self-analysis than your previous experience. The quiet deference of the sister, the obvious respect of the nurse; the amiable camaraderie of your chief, all combine to fill you with a delightful pride in yourself. But curb it. For when the day of your appointment is over and you face the olden world, you are no longer a fetish but just an ordinary bit of wood. What you will have gained in your time as a resident, what will be of never-ceasing value to you in your after-life, apart from your professional experience and your hall-mark, will be the friendship, the true friendship, of a number of your equals. Men whom you have never appreciated, may pass the refining fires of residency with a new lustre, and a new value, and at the same time, with equal truth, men of dross will perish utterly. In your six months of your year you will have seen men in their true light; you will have modified many hasty impressions and discarded many erroneous beliefs, and in the end you will depart richer in wisdom, in experience, but above all in the leaven of life—true friendship. So mote it be.

Some Remarks on Accuracy in Diagnosis or Clinical Precision.

A FEW OF THE CAUSES OF FAILURE.

A Paper read before the Medical Society of Manchester by W. H. A. JACOBSON, M.Ch. Oxon., at the invitation of Dr. Ashby (an old Guy's man).

MR. PRESIDENT AND GENTLEMEN,—I shall waste no time in making that apology which usually falls from the lips of one standing in the position which I occupy to-night.

Some, if not many of you, know that I owe the honour of my being here to-night solely to an ancient friendship, to one of twenty-four years' standing, between your President and myself, a friendship over which no cloud has ever once arisen; and I can only trust that his well-known *bonhomie*, his good fellowship, his eminently sunny, winning temper—I can but trust that these, gentlemen, which are only some of the traits with which your President is richly blessed, may excuse and lessen my shortcomings to-night.

As to the choice of a subject, I was much perplexed in the selection of one fitted to and worthy of this occasion and this audience. It would have been very easy to have chosen a surgical subject to bring before you to-night, but this seemed to me to be open to two very obvious objections. This meeting numbers some to whom Surgery has no especial attractions, and in bringing before you a surgical subject, I, an habitual teacher of students whom one can, perhaps, hope to teach, might have been betrayed, however much I tried to strive to the contrary, into treating this audience, whose reputation and professional knowledge far exceed my own, as if I were presuming to instruct you also.

My selection of a subject, "Some Remarks on Accuracy in Diagnosis or Clinical Precision: A few of the Causes of Failure," is, I trust, free from the above-mentioned objections; it concerns alike Physicians and Surgeons, and as I shall chiefly illustrate my matter by mistakes

which I have made or seen made—they are largely my own—while I may perhaps help on some present, I shall run no risk of seeming to teach or lay down the law to such an audience as this.

I am well aware that in alluding to mistakes, still more in making them a somewhat prominent feature, I run no small risk of being misunderstood. There used to be an old saying that "The man who never makes mistakes never makes anything." To-day, that eminently wise saying is in danger of being forgotten or perverted. It should run nowadays: "The man who makes mistakes—and is bold enough to say so—never makes anything else." These are the days of hurry and competition. Most people, nowadays, are so knowing, I might say so omniscient, so wary, so proud of the accuracy of their diagnosis as the proof of their success, that it requires an habitual and single-eyed love of truth to overcome such obstacles as a not unnatural pride and preference for recording successes only, instead of from time to time faithfully registering errors and mistakes. For the lessons which these teach are quite as valuable in their way as the uninterrupted roll of successes, with here and there especial prominence to the *miracles of our profession*, which are usually placed before our eyes.

I have subdivided my subject, SOME REMARKS ON ACCURACY IN DIAGNOSIS, OR CLINICAL PRECISION: A FEW OF THE MORE COMMON CAUSES OF FAILURE, into the following heads:—

i. *Neglecting or misinterpreting faint hints.*

ii. *Taking the opinions of others for granted.*

iii. *Too great reliance on book-teaching.*

iv. *Overlooking the patient or not duly weighing the patient's account in the disease.*

v. *Hurry in diagnosis.*

It is to the first of these that I shall give especial prominence, because I find from a study of my old case-books that it is here that I have learnt my chief lessons.

i. *Neglecting, overlooking or misinterpreting faint hints or minute points in the diagnosis of obscure and difficult cases. Neglect of the example of Zadig.*—Most of us, when we look back with the light of after the event wisdom on those cases which baffled us, and in which we made a wrong diagnosis, most of us would allow that, almost invariably, some minute point—often more than one—was present, which would have cleared up the case, and which would have prevented any mistake had one been only keen enough to perceive it. And more than this, most of us would allow that one or more of these minute sign-posts of points often appeared early in the case, just when they were most valuable. For if recognised then, and rightly interpreted, they might have led to a right course of treatment being initiated, or to the patient not leaving us and going, later, when perhaps the diagnosis was clear enough, to some one else.

I have referred to the example which has been set us by Zadig. Some of you may remember that Professor Huxley[1], in one of his essays, and Professor Cuvier[2], before him, applied this method of Zadig, *i.e.*, the study of minute details, to the science of Palæontology.

Voltaire tells us that, disenchanted with life by sundry domestic misadventures, Zadig withdrew from the turmoil of Babylon to a secluded retreat on the banks of the Euphrates, where he beguiled his solitude by the study of Nature. Incessant and patient observation of the plants and animals about him sharpened his naturally good powers of observation and of reasoning, until at length he acquired a sagacity which enabled him to perceive endless minute differences amongst objects which, to the untutored eye, appeared absolutely alike.

One day, walking near a little wood, he saw hastening that way one of the Queen's chief eunuchs, followed by a troop of officials, who appeared to be in the greatest anxiety, running hither and thither like men distraught, in search of some lost treasure.

"Young man," cried the eunuch, "have you seen the Queen's dog?" Zadig answered modestly, "A bitch, I think, not a dog." "Quite right," replied the eunuch; and Zadig continued, "A very small spaniel who has lately had puppies; she limps with the left fore-leg, and has very long ears." "Ah! you have seen

[1] Nineteenth Century, 1880. Essays on Science and Hebrew Traditions, p. 1.

[2] Recherches au les ossemens Fossiles, t. i. p. 185.

her, then," said the breathless eunuch. "No," answered Zadig, "I have not seen her, and I was really not aware that the Queen possessed a spaniel."

By an odd coincidence, at the very same time, the handsomest horse in the King's stables broke away from his groom in the Babylonian plains. The grand huntsman and all his staff were seeking the horse with as much anxiety as the eunuch and his people the spaniel, and the grand huntsman asked Zadig if he had seen the King's horse go that way.

"A first-rate galloper," replied Zadig, "small hoofed, five feet high; tail three feet and a half long; cheek-pieces of the bit of twenty-three carat gold, and shoes of silver." "Which way did he go? Where is he?" cried the grand huntsman. "I have not seen anything of the horse, and never heard of him before," replied Zadig.

The grand huntsman and the chief eunuch made sure that Zadig had seen both the horse and the spaniel, so they haled him before the High Court, which condemned him to the knout and transportation for life. But sentence was hardly pronounced when the lost horse and spaniel were found, so the judges were under the painful necessity of reconsidering their decision, but they fined Zadig four hundred ounces of gold for saying that he had seen what he had not seen.

The first thing was to pay the fine. Afterwards Zadig was permitted to open his defence to the court, which he did in the following terms:—"Stars of justice, abysses of knowledge, mirrors of truth, whose gravity is as that of lead, whose inflexibility is as that of iron, who rival the diamond in clearness, and possess no little affinity with gold; since I am permitted to address your august assembly, I swear by Ormuzd that I have never seen the respectable lady-dog of the Queen, or the sacrosanct horse of the King of Kings.

"This is what happened. I was walking towards the little wood near which I subsequently had the honour to meet the venerable chief eunuch and the most illustrious grand huntsman. I noticed the track of an animal in the sand, and it was easy to see that it was that of a small dog. Long faint streaks upon the little elevations of sand between the foot-marks convinced me that it was a she-dog with pendent dugs, showing that she must have had puppies not many days since. Other scrapings of the sand, which always lay close to the marks of the fore paws, indicated that she had very long ears, and as the imprint of one foot was always fainter than those of the other three, I judged that the lady-dog of our august Queen was, if I may venture to say so, a little lame.

"With respect to the horse of the King of Kings, permit me to observe that, wandering through the paths which traverse the wood, I noticed the marks of horse-shoes. They were all equidistant. 'Ah,' said I, 'this is a famous galloper.' In a narrow alley, only seven feet wide, the dust upon the trunks of the trees was disturbed at three feet and a half from the middle of the path. 'This horse,' said I to myself, 'has a tail three feet and a half long, and lashing it from one side to another, he has swept away the dust.' Branches of the trees met overhead at the height of five feet, and under them I saw newly fallen leaves; so I knew that the horse had brushed some of the branches, and was therefore five feet high. As to its bit, it must have been of twenty-three carat gold, for he had rubbed it against a stone, which turned out to be a touchstone, with the properties of which I was familiar by experiment. Lastly, by the marks which his shoes left upon pebbles of another kind, I was led to believe that his shoes were of fine silver."

All the judges admired Zadig's profound and subtle discernment, and the fame of it reached even the King and Queen. From the ante-room to the presence-chamber Zadig's name was in everybody's mouth; and although many of the magi were of opinion that he ought to be burnt as a sorcerer, the King commanded that the four hundred ounces of gold should be restored to him. So the officers of the court went in state with the four hundred ounces, only they retained three hundred and ninety-eight for legal expenses, and their servants also expected fees.

I will now bring before you some cases in which *overlooking minute points* led to failure in clearing up important cases and, in some, to needless disasters.

R. R., æt. 35, a collier, was sent to me in January, 1894, by Dr. Naunton Davies, of Pontypridd, with the symptoms of a renal calculus on the right side. He was markedly pallid, and about the bony prominences of the face, forehead, malar bones, nose and temple were many of the bluish streaks so characteristic of his work.

At an operation on January 30th, at 2 p.m., an indurated spot on the front of the kidney was easily detected, and by an incision, half an inch long, over the outer border of the kidney, and quite at the lower end, a small, irregular-shaped, oxalate calculus, weighing 30 grains, was easily turned out.

The edges of the incision in the kidney were sutured to the deep lips of the wound so as to fix the kidney within reach. The patient's pulse was very feeble after the operation, which only lasted five and thirty minutes. On account of this condition of the pulse I did not leave the hospital till 5 o'clock, when nothing had come through the dressings. At 5.15 blood was noticed to be oozing through, and as the patient quickly became collapsed, transfusion was performed at 6. The patient rallied, becoming warm and speaking with a good voice at 6.45, when I saw him again. At 9.30 bleeding, together with urine, reappeared; the wound was opened up under ether, and the blood found to be of the nature of an oozing from the small wound in the kidney. This oozing was at once arrested by grasping the lower end of this organ and by firm plugging with gauze. But the patient's collapse deepened, though transfusion was again performed, and he died about 9.45 a.m., January 31st, or 16 hours after the operation. The hæmorrhage was entirely unaccompanied by clots, and the whole amount lost was estimated at about 5 ounces. The autopsy showed a small clean-cut wound in the kidney, with slight hæmorrhage around. In the substance of the kidney, close to this wound, lay another tiny calculus, which had been overlooked at the operation. There was marked contraction of the mitral valve.

I had noticed the pallor in this patient, but as his face showed several of those characteristic blue marks from the contact with coal so often met with in miners—I put the pallor down to the fact that the man spent much of his time underground. Had I done my duty, and gone further and found the heart disease, I should certainly have run some risk and closed with sutures the incision in the kidney itself, from which the stone was taken.

There is no doubt that the subjects of mitral disease often last a very long time. Dr. Goodhart attributes this fact to "the enormous reservoir-area that there is in lungs and liver, etc." This is no doubt correct; but if we interfere with those reservoirs and the damaged heart, either by the disturbance of anæsthetics or by tapping one of these reservoirs themselves, we must make up our minds to face trouble. On the subject of surgical hæmorrhage and mitral disease, I have, since my case, heard of a case of thyroidectomy in a patient with mitral disease in which fatal hæmorrhage followed the operation, and I am given to understand that experienced general practitioners are familiar with severe and sometimes baffling hæmorrhage during confinements in which this complication is present.

I have here spoken of two cases in which *pallor*, a minute point in itself, was yet a decided hint both as to diagnosis and treatment. I will mention another hint of the same apparently trifling kind on which much turned. I refer now to *tremor*. Six years ago, a woman of 48, with carcinoma of the left bosom, was sent to me by an aged practitioner, now deceased, at Watford. The patient had had reverses in life, and noticing tremor of her tongue and hands I thought that she might have been in the habit of flying to alcohol for support in her troubles. Enquiry of her medical man seemed to negative the idea, and I foolishly let the matter slip from my mind. After the operation the patient was, from the very first, helpless and inert. She was ever asking for stimulants, and the cry, "Give me morphia," was perpetually on her lips. It was

impossible to get her to take fitting or sufficient nourishment, and she, habitually, lay prostrate at the bottom of her bed. The flaps separated in part, the patient became increasingly feeble, and taking less and less food but asking for morphia to the last, she sank exhausted within two days of four weeks after the operation. It subsequently transpired that the woman had been in the habit of taking morphia in the liquid form.

While dealing with single symptoms, I will mention one other, *strabismus*. I shall refer to this point again when I allude to the mistakes in diagnosis which we are liable to make because we forget how often the manifestations of this and that disease tend to be "atypical." The case I now mention is very briefly given by Dr. Markham Skerritt in an address recently given before the Bristol Medico-Chirurgical Society. "A medical man asked him to be present at the necropsy of a girl who had been recognised as purely hysterical by several eminent authorities. She had a slight squint which did not attract much notice. One day the girl had an 'upset' with her friends, went into the garden in a fit of hysterical crying and fell down dead. An enormous cerebral tumour existed.

I selected the next two cases because they are examples, the one of aneurysm, a disease which with us down South is becoming less frequently met with in all ranks of life, both by physicians and surgeons; the other a case of appendicitis, which, on the other hand, is increasing in frequency. I had nothing to do with either case, but both the physicians are well known to me.

[3]A gentleman, who before his death in 1876 had been seen by many prominent members of the profession, first felt ill in January, 1872, when he had swelling of the left testis, together with pain. Then followed pain in the region of the left ureter. At first the pain was dull and heavy, but it gradually became agonizing. Change of position gave no relief. Pain was also felt in the lower bowel. This went on for several months and then he had constipation and vomiting. The pain was worse when the bowels were moved. At this time the patient was apparently *in extremis* and had several bedsores. The abdomen was soft and not tender on gentle pressure; deep pressure, however, to the left of the umbilicus caused severe pain. The diagnosis formed was that there was a growth in the descending colon involving the left kidney and ureter, and probably malignant in character from the cachectic appearance of the patient. There were no symptoms pointing to renal calculus. Shortly after the pain abated, and the patient improved in every way. Fifteen months later the patient's health again failed. Pulsation could now be felt, and became definite at the spot where the pain was originally felt. But there was now no pain. One day while the patient was at dinner, the old look of pain suddenly returned, the patient became unconscious and fainted, but gradually rallied. Two days later he passed a quantity of black blood by the bowel. He partially recovered, but a week later, while again at dinner, he suddenly gave a cry and fell dead. At the necropsy, an aneurysm was found springing from the left side of the aorta, and protruding between the left colon and the ureter. It was of the size of a fist, and opened into the descending colon.

Here the first hint in this case which pointed clearly to its nature was the early painful swelling of the left testicle. It may recall to some of my readers a case which Wardrop gives in a note to his edition of Baillie's Works, vol. ii., p. 319. A man, both of whose testicles were completely absorbed, nothing being felt in the scrotum but a loose vaginal coat, died of an aneurysm of the aorta, formed at the origin of the spermatic arteries, both of which were obliterated.

In the case of the gentleman the pain, no doubt, due to irritation of the spermatic plexus, was naturally taken for that caused by a renal calculus. But, as I said with regard to these minute points and their exceeding value, they often appear early in the course of the disease, and often they do not come alone. Thus, here there was first the pain in the left testicle, then pain in the back, at first dull and heavy, then agonizing, but all along not relieved by change of position. I suppose if we are called to a case of obstinate pain in the back in a patient after middle life we think of three things—caries, aneurysm, malignant disease. If the pain is not

[3]Dr. Dickinson, Path. Soc. Trs, 1875, vol. xxvi, p. 76.

relieved by rest we can exclude the first. Then in this case, a little later, the pain was felt in the lower bowel and was worst when the bowels moved. It is easy, of course, in the light of after-the-event wisdom to string these points together, but what a light they throw upon the early obscurity of this case!

If I do not weary you with these cases emphasizing the value of minute points in clearing up difficult and important cases of diagnosis, I would turn to the appendix in which inflammatory changes, sloughing, suppuration, seem so decidedly on the increase.

The first case was associated with that most fatal lesion, septic abscess in the liver; though here, as is unfortunately rare, the abscess was single. The case was diagnosed as pneumonia, secondary probably to some disease in the abdomen. I propose, with the wisdom which is so easy after the event, to point out the faint hints which, from the first, pointed strongly in the direction of the cause.

[4]A boy, æt. 12, was admitted into Guy's Hospital in 1869, under one of our former physicians, with the history that three days before while sitting quietly after dinner he was suddenly seized with severe abdominal pain, which lasted about eighteen hours, during which time the boy was very sick. After admission the sickness stopped, and the pain which was referred chiefly to the right hypochondrium was little complained of save when the patient was sitting up. Evidence of pneumonia of the right lung gradually developed, and five days later seemed to begin to subside, but while the abdomen was flat at first, there was marked spasm of the right rectus, and in the right hypochondrium there was a decidedly tender spot, and percussion over this point was always painful. As the pneumonia appeared to subside the upper part of the abdomen became tumid. The boy sank fourteen days after the stated commencement of his illness, and the autopsy showed a large abscess in the upper surface of the liver which had perforated the diaphragm and led into an excavation in the base of the right lung.

[4] A Case of Abscess between the Diaphragm and Liver. By Frederick Taylor, M.D., Guy's Hospital Reports, 1874, p. 257.

In a collection of pus found in the righ inguinal and retro-vesical regions were two brownish, soft, friable concretions which had clearly escaped from an ulcerating appendix cæci.

Now it is clear that in a case running on the like lines, the history of the pain and vomiting coming on suddenly after a meal, the rigidity of the right rectus, the tenderness in the right hypochondrium, the enlargement or descent of the liver, were all minute points—and some showing themselves from the first—which might lead to the saving of a patient's life by surgical interference.

The next case ended more happily, but I venture to think that Zadig, had he had all my surgical opportunities, would not have needed an operation to reveal the very interesting condition found, and the thread on which the patient's life was hanging.

A gentleman, æt. 23, was sent to me in July, 1896, by Dr. Goodhart, with the following history:—In 1895 he had had a severe attack of appendicitis, in which the temperature for some days was between 102° and 103°. Under medical treatment he made an apparently perfect recovery. In June, 1896, while bowling for an eleven of the Zingari in this city, as he shot up to the crease he suddenly felt an acute pain in the right iliac fossa, and dropped to the ground. He was carried to an hotel in a state of collapse, and when the mischief had abated, came into my hands as I have said. There was the characteristic thickened knotty lump and tenderness at one small spot in the right iliac fossa, and the appendix when removed showed much evidence of old thickening in its distal half, but save for the adhesion of a single tag of omentum at one spot, the appendix struck me as being strangely free from adhesions, considering the severity of the two attacks. I happened, after the operation, to pass a probe down the lumen of the appendix, when, to my surprise, the blunt end passed, without the slightest force, through the walls at one spot exactly where the tag of omentum was adherent. Here the end could be seen just covered by a filmy layer of peritoneum only. A surgical Zadig would have foretold before what an operation had been

needed for me to clear up. He would have pointed out from the first severe attack with a temperature of 103°, but no evidence of a localised abscess, that the appendix had suffered severely in its structure, and that one or more adhesions had formed, probably omental, and preventing an imminent rupture of the appendix. That as the patient was bowling his very best, the uplifted arm and the rotation of the whole trunk upon one leg brought, by means of the latissimus dorsi, pectoralis major, external oblique—all continuous with each other and with the muscles of the limb at Poupart's ligament—a violent strain upon the abdominal wall and so upon the omental tag, causing a stretching here and perhaps a minute tear, and, thus, the agonizing pain and collapse.

I will now mention two cases in which attention to small points ensured a correct diagnosis.

I was called in April, 1897, to Milford Haven to see a lady who was suffering from some obscure bladder affection. The frequent and painful micturition day and night, the presence of pus, the scanty but occasional hæmaturia made me suggest tubercular cystitis. This diagnosis was not acceptable to the medical men, and was scouted by the patient's mother, an old lady of eighty-one. The father had died of apoplexy, and the only other child of the marriage had recently been carried off by typhoid fever at the age of thirty-three. Had not the patient, I was told, lived all her life in a house high up on the hills above that glorious inland sea, with the winds blowing from every point of heaven, and did she not spend the summer at another house which the family possessed near Bettws-y-coed. The appearance of the patient herself at fifty-one, and the mother thirty years older, only confirmed my opinion. It was impossible as one looked at these ladies—and the pair of them recalled exquisite Sèvres china—not to see certain traits and points, *e.g.*, the long silky eyelashes, the fair transparent skin, the delicacy and vulnerabitity at every point which suggested the thought, "put the clocks of these lives back five-and-sixty and five-and-thirty years, and what pictures they would be of the old-fashioned but expressive term 'pretty struma.'" It proved an instance of the importance to us of studying constitutions even in trifles, just as in other professions men have to be judges of character. And I am sure, as we grow older and perhaps wiser, when we compare our knowledge with that which we thought we had thirty or forty years ago, we see that we pride ourselves on the diagnosis of many difficult cases more and more by the study of the patient's past and constitution, detecting evidence often of much confirmatory importance in signs which to others appear trivial.

I suggested that the patient should take an anæsthetic for examination of the bladder. I investigated carefully for evidence confirmatory of my opinion. A small weeping sinus over the eighth rib on the left side at once suggested quiescent tubercular caries. When I questioned the mother about this and its duration the answer was, "Oh, its eighteen years ago since I took her to Sir ——," an eminent surgeon then with us, "and he advised that the abscess should be allowed to burst and be left alone."

The diagnosis was strongly confirmed by the discovery of this small point, kept to herself by the patient, and forgotten by the mother. Its correctness was absolutely confirmed by the discovery of tubercle bacilli in the urine on more than one occasion subsequently.

Mr. S., æt. 60, was sent to me from Southsea, in April of this year, with a large, hard right testicle and hydrocele. The swelling was stated to have begun, perhaps during riding over very unlevel ground, a year and a half before. It had increased steadily till eight weeks before the date of my seeing the patient, when the progress had become rapid. A definite opinion had been given that the disease was malignant and that, owing to the state of the cord, the time for castration had gone by. The condition of the cord was extraordinary. It was enormously enlarged and massive, from just above the testis to the internal ring it was four or five times its proper size, owing to swellings, firm and free from tenderness, the size of bantam's eggs. Into these all the constituents of the cord appeared to enter. The vas was lost in them. The vessels did not appear to be enlarged. To

make a long story short, the only thing besides malignant disease that we could have before us was gummatous disease. The other testis had never been affected. The patient denied syphilis absolutely. His tongue, so often a tell-tale member in this disease, showed two small patches of leucoplakia. No other trace of the disease could be found. Now, while other high authorities have taught that leucoma and leucoplakia may be due to other sources than syphilis, such as excessive smoking, eating of curries, devils, etc., ill-fitting teeth-plates, and the like, I have held for a long time that syphilis is, to some degree, always at the foundation of these patches. As the patient was in great anxiety about his condition after the opinion given, and as he was sixty, it was thought better to lose no time and to remove the testis. This and the cord proved to be the seat of gummatous deposits, typical in appearance though most unusual from their enormous size. It subsequently came out that the patient, who had risen to a very high appointment in the Post Office in India, had originally gone out to Singapore before the mast, and that the syphilis had been contracted nearly forty years ago. He had married and been the father of healthy children, and had had no reminder of his syphilis till this jolting journey affected his degenerating tissues nearly forty years later.

That facile writer, Sir Lauder Brunton, whose papers are as instructive as they are interesting, in a lecture on the need of tracing symptoms back to their causes, gives these additional instances of the method of Zadig.[5] One story is told of an old fakir in the Syrian desert. He was one day visited by several Arabs, who asked him if he had seen their lost camel. "It was very tall," said the fakir, "it was blind in the right eye, it had lost one of its front teeth, and it was laden on the one side with honey, and on the other side with corn." "Yes," said the Arabs, "this is exactly the camel; you have mentioned every point about it. Where is it?" "I have never seen your camel," said the fakir. "But if you have not seen it," replied the Arabs, "how can you know all about it?" "I know that it was a very tall camel because the tracks of its steps in the sand were further apart than those of a camel of ordinary size. I know that it was blind of the right eye because it had cropped the herbage only on its left side, and I know that it had lost one of its front teeth because in the middle of every bite that it had taken there was a small uncut part corresponding to where the tooth ought to have been. I know that it had been laden with honey on the one side and with corn on the other, because I saw flies buzzing round one side of the track, and ants busy on the other carrying away grains of corn that had fallen from the load."

Sir Lauder Brunton goes on to tell another admirable example of this method of tracking disease by minute points, which used to be told, with great gusto, by his friend Dr. Milner Fothergill. In the town of Leeds there once lived a quack who had received no professional education whatever, but was known far and wide for his wonderful cures, and especially for his power of diagnosing the diseases of patients whom he had never seen by simply examining their urine. A celebrated surgeon wishing to see his method of working, desired to be presented one day, and the quack readily acceded to his request, feeling much flattered that so great a man should patronise him. Shortly after the surgeon had taken his seat, a woman came in with a bottle of urine, which she handed to the quack. He looked carefully at her, then at the bottle, held it up between him and the light, shook it, and said: "Your husband's?" "Yes, sir." "He is a good deal older than you?" "Yes, sir." "He is a tailor. He lives at Scarcroft?" "Yes, sir." "His bowels are obstinate?" "Yes, Sir." "Here," he said, handing her a box of pills, "tell him to take one of these pills every night for a week, and a big drink of cold water every morning, and he will soon be all right." No sooner had the woman gone out than the surgeon turned to the quack, anxious to know how he had made out all this. "Well, you see," said the quack, "she was a young woman, and looked well and strong, and I guessed the water was not hers. As I saw she had a wedding-ring on her finger I knew she was married, and I thought the chances were

[5] Lan., 1892, vol. i., p. 4.

it was her husband's water. If he had been about the same age as she was it was hardly likely that he was going to be ill either, so I guessed he was older. I knew he was a tailor because the bottle was not stopped with a cork, but with a bit of paper rolled up and tied with a thread in a way that no one but a tailor could have done it. Tailors get no exercise, and consequently they are all very apt to be constipated. I was quite sure he would be no exception to the rule, and so gave him opening pills." "But how did you know she came from Scarcroft?" "Oh, Mr. So-and-so, have you lived so long in Leeds and you don't know the colour of Scarcroft clay? It was the first thing I saw on her boots the moment she came in."

II. *Taking the opinions of others for granted.*—While, as far as our profession is concerned, I am far from agreeing with Professor Stewart, who, in his Moral Philosophy, teaches that reverence for great names is one of the chief hindrances to the spread of real knowledge, I can remember incorrect diagnoses which I have made from following too closely the opinions of others.

To give an instance:—

A lad, æt. 14, came to me at Guy's Hospital last June with an acute swelling of the right side of the scrotum and its contents. Now this was a case of that disease which is not so rare as represented—torsion of the testis. And most of those who have written on the subject have stated that general symptoms as well as local are usually present with torsion of the testis, *e.g.*, vomiting, constipation, and perhaps some swelling of the abdomen, pointing to the possibility of strangulated hernia. Because all these were absent; because, save for the local trouble, the boy was absolutely well; I overlooked the possibility of torsion of the testis, and did the boy a double injustice by attributing the inflammation to some excessive venereal excitement, probably masturbation, a form of inflammation noticed by Brodie, Curling, and Hutchinson, as likely to be followed by atrophy. The inflammation not yielding to ordinary treatment, the parts were explored, and a typical torsion of the testis found with the usual absence of any mesorchium.

Here my diagnosis was faulty from two causes (i.) in following what others have taught. We know with what gentle irony the Poet-Physician whose tongue was lately hushed, and from whose fingers dropped one of the most versatile, but ever one of the most refined pens that ever wrote, referred to this error. I refer, of course, to Oliver Wendell Holmes in his Song of the Stethoscope:—

"Then out his stethoscope he took,
And on it placed his curious ear,
'*Mon Dieu*,' said he, with a knowing look,
'Why, here is a sound that's mighty queer!
The *bourdonnement* is very clear,
Amphoric buzzing as I'm alive!
Five doctors took their turn to hear,
'Amphoric buzzing,' said all the five."

(ii.) in forgetting that because in 6 cases of torsion of the testis with which I was familiar, a certain collection of symptoms had been present they necessarily would be present in the seventh, a form of reasoning which is thus severely rebuked by Bacon:—

"*Inductio quæ procedit per enumerationem simplicem res puerilis est.*

Allied to the above is another cause of error in diagnosis, viz.:—

III. *Following too closely the teaching of books*, that teaching which is handed down, from writer to writer, to one generation of students after another.

Let me take one or two instances which appear to me to be sources of important mistakes in diagnosis.

To turn for a moment to head injuries, every book as it comes out gives clearly the symptoms of concussion and compression, and so far no doubt they do well. But it would be infinitely better and might save many mistakes if, after tabulating the distinctive points between compression and concussion they went a little farther and shewed what every hospital surgeon here to-night has learnt, that concussion and compression of a serious degree rarely occur alone, and when they do occur alone they are not of their greatest importance. Every one here knows that when a patient is suffering from concussion alone he will get well with rest and medical treatment in ninety-nine cases out of a hundred.

And when a case shows evidence of compression alone after a head injury, we know that, if no time is lost, if we by prompt surgical interference can remove the source of compression, whether a bit of the skull or a middle meningeal clot, the patient will do well.

But the books, I submit, should go farther, and instead of leaving the student to imagine that simple concussion and simple compression are often met with after head injuries, that if he remembers the distinctive tabulations of their symptoms he will be able to recognise each and deal with it, they should, I maintain, go farther, and put with equal clearness before the student the following points. That no sharp line can be drawn between severe concussion and compression. That as concussion, paramount at first, passes off, other lesions, compression, laceration, etc., may appear. That concussion and compression usually, and in their most important form, do not occur alone, but occur together and combined, also, with contusion and laceration of the brain. That contusion and laceration are more frequently met with than simple concussion and simple compression, and are thus of infinitely greater importance. That while contusion and laceration of the brain may, at certain points, produce much the same evidence, to wit, hemiplegia, as will a depressed fracture or middle meningeal hæmorrhage or apoplexy, they often (if severe) have no symptoms of their own, for in contusion and laceration the special and motor centres are often not picked out, and the parts that are affected have, as yet, no definitely known symptoms.

I maintain, to prove my point, that if the books taught such clinical facts as these written on less narrow lines, and if each writer as he writes his book thought more and copied less, we hospital surgeons would not have those cases with which most of us are familiar occurring from time to time, injuring our institutions, because at the inquest an ignorant juryman cannot understand why what is so terribly clear at the silence of the necropsy was not equally evident during the few hours of the life of the patient. I refer to one of those cases of fracture of the posterior fossa, so especially liable to be overlooked or wrongly diagnosed and treated as drunk and not needing admission. "A man is picked up in the street, no accident has been seen; if not already drunk, he is dosed with brandy at the nearest public house, and brought to the hospital, often late at night. The patient is dull and drowsy, in a state of mind easily taken for tipsiness, especially if his breath smells of alcohol, and, as not infrequently happens he vomits some. The injury to the head is very liable to be overlooked, as it is on the back of the head, and may be only a contusion or a small scalp wound, and it is on a part where the hair is thick. The patient is very likely sent away as partly drunk and partly "stunned." After a few hours he is readmitted with severe headache and with intermitting drowsiness and restlessness, a rising pulse and temperature. The scene closes rapidly with coma and stertor, and at the necropsy a fissure-fracture of the posterior fossa is found with some intradural hæmorrhage, severe bruising of the frontal and occipital lobes, and intense congestion of the brain surface." Battle (Hunterian Lectures).

Let me turn to another subject in which the teaching of books has, I think, been most faulty; I refer to cancer of the bosom and whether cancer is curable. Thus it is said[6] that "the course of an ordinary cancer of the breast, unrelieved by treatment, may be divided into three stages. *First*, when the disease is limited to the gland; *secondly*, the stage of implication of the skin and the axillary glands; and *thirdly*, the stage of ulceration and general infection." And then the authority of Goss is quoted, as giving on an average fourteen months for the first, six for the second, and seven for the third stage, or twenty-seven months in all.

Now I have no objection to this twenty-seven months as giving, with sufficient accuracy, the average duration of life after the first appearance of the disease. But I hold most strongly that the duration of time—fourteen months—which is given to the first stage, is most fallacious, and fraught with errors, as sad, as they are irremediable.

The student and practitioner remembers this fourteen months, and when a patient comes

[6] Beck. Diseases of the Breast. Dictionary of Surgery, vol. i., p. 125.

before them with a doubtful swelling, ultimately carcinoma, and the patient, as usual, gives a history of a few weeks, they possess their soul in patience and lose most precious time.

Now what ought to be taught is, that as to this first stage of cancer we know next to nothing. That at first there is entire painlessness and absence of much, if anything, to see; that the cells, the elements of the malignant disease, are situated from the very first in the connective tissue spaces of the breast stroma, and thus are ready to be washed at any moment into the lymphatics by the lymph stream; and that while the "lump" for which our advice is sought is apparently single, secondary minute foci are usually present, often at some distance from the first.

Now, Mr. President and Gentlemen, if the above be correct, it is clear that to teach that the average duration of the first stage of cancer is fourteen months is absurd if not dishonest. It is a stage which *must* be variable, depending as it does whether the cancer cells have reached the axillary lymphatics, on the rate at which the lymph circulates, on the functional activity of the bosom, on the activity of its circulation, and on the variety of the cancer cells. Being thus of necessity variable, in some cases instead of fourteen months a fewer number of weeks only may elapse before the lymphatic glands are reached, though, all along, the danger here may be imperceptible.

Now, if the above view of the first stage of cancer of the bosom be the correct one, what should be our teaching to our students– not, of course, to our patients—on the curability of cancer. Surely on this subject the trumpet of authority of our books should give out no uncertain sound.

If asked whether I consider cancer curable, I reply only if it be taken in the very earliest stage can a permanent cure be looked for, and it must always be remembered how handicapped we are by the almost entire absence of information which cancer gives in its earliest stage and the variable rate at which its early stages run.

Such teaching makes one liable to be called a pessimist, a teacher that cancer is incurable, and to other misrepresentations.

It is very easy and very pleasant, Mr. President, to be able to put on the cloak of optimism, and to say: "I am very sorry for you pessimists, as for me I am an optimist, and Volckmann's dictum that if three years pass after operation without recurrence the patient is cured is quite good enough for me." But, Mr. President and Gentlemen, there is one thing that is above optimism and pessimism and that is the truth. I hold that Volckmann's teaching is false and most fallacious. I reply that my belief that cancer is only certainly curable in its very earliest stage, my having to admit that this earliest stage by some mysterious dispensation gives us but little evidence only makes me endeavour to be more alert in detecting that evidence, only leads me when operating to do so at the very earliest moment and on the widest possible lines, and above all to seize every opportunity of operating in those doubtful cases—I will call them for brevity precancerous, in which conditions of chronic irritations at first starting often in pathological sympathy with the uterus and ovaries gradually pass on into actual carcinoma. The frequency with which these chronic irritations develop, persist rebellious to treatment, and ultimately become carcinomatous, are, I believe on the increase owing to the environments and exigencies of modern life.

I have been alluding to *the teaching of books* and the errors which may arise therefrom. Let me draw your attention to another and allied source of error. I refer to what are called *typical cases*, and the tendency many of us have felt to miss making a right diagnosis, because some of the points which go together in making it a typical case of such and such a disease were absent.

I will take, please, tubercular meningitis. We all know the description of a typical case with its three stages and its duration of two or three weeks. But it is not sufficiently known, Sir, save to those who have read accounts as careful as that of your colleague and my old co-æval, Dr. Ashby, how often the typical and characteristic symptoms are wanting, especially

in the young, from whom one can get so little help.

I remember in July last, while visiting at the Children's Hospital, with which I am connected, that the House Surgeon drew my attention to an infant which had been admitted a few days before with tubercular glands of the neck and disease of the os calcis. At this time the child's condition, locally and generally, was one of wretched neglect, but there was a something about the child which, together with a temperature of 99°, put down to teething, led me to defer any operative steps. When I saw it again, four days after admission, the head was a little retracted, but saving for this, and a temperature of 100·2, there was nothing to point to serious mischief. There was no vomiting, no strabismus, no convulsions or twitching of muscles. In three days the child was dead of meningitis distinctly tubercular. Mr. Howard Marsh gives a still more instructive case of this kind.[7] A young lady of fourteen whom, he was attending for hip disease, was constipated, and her mother gave her an aperient. This was followed by severe abdominal pain. The bowels did not act, but there was persistent vomiting, followed by great exhaustion almost amounting to collapse. The eyes were sunken and the features indicated great distress. These symptoms strongly suggested acute obstruction, such as might be produced by strangulation of a loop of small intestine by a band. But as the abdomen was quite free from tension, and as no localised swelling could be felt, it was determined to postpone laparotomy, for which every preparation had been made. A few hours sufficed to show how fortunate it was that this course was adopted. The child proved to be suffering from acute tubercular meningitis. It was to this that the urgent sickness was due. The pain was mere griping from the aperient. The collapse was produced by the constant vomiting. The case was most misleading, for at first there were no cerebral symptoms whatever to be observed. The child had no headache, no photophobia, convulsions, strabismus, slow pulse or irregularity of pupils.

IV. *Overlooking the patient, or the patient's account of the case in the disease.*—Both of these are liable to lead to incorrect diagnosis. As time presses, I have placed them together. And first as to *mistakes which may arise from not paying attention to what the patient tells us, especially when his statement seems improbable.* I well remember one case nearly twenty years ago. A surgeon while going round his male ward was shown a patient with a large right scrotal hernia, in a state that bordered between incarceration and strangulation. The man volunteered the observation that whenever pressure was made on the hernia he felt a desire to pass water. This most unusual statement did not receive the credit, which, as was easily seen afterwards it deserved. The surgeon, a man of fine physique and kingly presence, took prolonged trouble and applied much force in reducing the hernia. After some of the contents had been returned he desired a dresser to complete the reduction. About two hours later, I, as assistant surgeon, was called to the patient whom I found in a condition of combined fatal collapse and early peritonitis. An exploratory incision showed not rupture of the intestine but of the bladder, the apex or upper part of which lay in the sac, from which urine was running into the peritoneal cavity. I think, perhaps, we who are on the staffs of hospitals, are in especial danger of underrating or overlooking the statements of patients, owing to the apprenticeship which we justly serve in the out-patients' room. The numbers to be seen there, the ignorance, the flippancy, and the indifference to exactness too often shown, lead us too much to trust to what we can make out by other means than the patient's information. In other words and those of the late Professor of Surgery at Cambridge, we follow two closely his *dictum*: "Eyes first and most, fingers next and less, tongue last and least."

I turn to the other sub-division of this heading. *Mistakes made in diagnosis by overlooking the patient in the disease.*—In each individual, as they come before us, the disease has to be studied afresh, the idiosyncracy, the temperament, the constitution of the patient, his surroundings—all and each have to be taken into account; or a diagnosis, though correct as a diagnosis, will be an incomplete one, and we

[7] *Lancet*, vol. i., 1897, p. 152.

shall be in danger, when we initiate treatment, of advising what may be very good for the disease as a name, but possibly bad or uncalled for in the case of the individual patient before us.

I will illustrate this, if you please, by a case of gouty neuralgia of the lingual gustatory nerve, treated with brilliant but short-lived success, by resection of an inch of the nerve, a step which I should not have taken, or which I should have foreseen would ultimately fail had I given more consideration to certain traits in the patient whom I was treating.

S. A. B., æt. 43, was sent me in 1894, by Dr. Osborn and Surgeon-Captain Salvage, of Woolwich. For twelve months the right half of the tongue had been the seat of obstinate neuralgia increasing in severity. The tongue itself looked normal, but several of the lower teeth on that side had been extracted for the pain. It was in all movements of the tongue that the pain was complained of. It was of a shooting, darting character, and was increasingly attacking the regions supplied by the inferior dental and auriculo-temporal. As the usual methods of arsenic, menthol, and injections of morphia into the tongue itself had failed, the right lingual gustatory was exposed by the method of Roser in the fold of mucous membrane between the right side of the tongue and the jaw, the centre of the incision being opposite to where the last molar tooth would have been. A full inch of the nerve was removed. The patient made a rapid recovery with complete loss of sensation over the right half and tip of the tongue. She soon lost her careworn, anxious look, her aspect becoming that of a woman ten years younger. When seen, two months after the operation, and asked whether she was glad if she had undergone the operation, she replied "I should think I am."

When I saw this patient again in 1898, about a year and a quarter after the operation, much of the old worn look had returned, and she stated that her mouth and tongue were again painful, though to a probe the right half of the tongue was still devoid of sensation.

Now to what was this failure of surgery, which at first looked so promising, due? I believe to the fact that in treating the disease I overlooked the patient. A more exact and scrutinising investigation brought out a number of small points in this patient which make me believe that the neuralgia of her tongue was of the nature of a gouty neuritis. Thus the patient had small scaly patches of eczema behind the ears and on both legs. She had obstinate constipation and prurigo ani. Four years before she had suffered from sciatica, and two years after from cervico-brachial neuralgia of the left side. She was liable to attacks of "hot" or "irritable" eye. She took beer habitually, and latterly, after this beverage, she had noticed "pricking" in her shoulder-joints, and there were three nodi digitorum (osseous, not tophic) on the fingers of one hand, and two on those of the other. Lastly, the patient was habitually over-taxing and worrying herself with constant indoor work in charge, together with her husband, of the plate and linen of the Royal Artillery Mess at Woolwich; never taking any holiday, and rarely any fresh air at all. All these minor points make me think that this patient's case was one of the modified or quiet gout, which we see so often in large towns nowadays, and that if I could have ensured wiser surroundings, regular and open air exercise, and a change of scene from her worries, I should have saved her a needless operation and myself a disappointing failure.

Now, Sir, I may perhaps in the eyes of some of those present, seem liable to the charge of "seeing gout in everything," but I have introduced this case in order to allude to a form of mistake which is, I think, being often made at the present time, *i.e.*, not estimating correctly the nature of gout as it is with us now, A D. 1903.

To make my meaning clear, I would say that I look upon gout as a state of the blood, and many of the tissues which used to be induced by errors of diet in the direction of surfeit, but which is now due, in the majority of cases, to defects in assimilation. These defects in assimilation are nowadays brought about (owing to the exigencies of modern life) by wear and tear, overwork and worry, twenty times as often as they are by surfeit.

The public needs educating on this point. A patient coming before us with some arthritic trouble, with gravel, with a relapsing iritis, with a neuralgia—all affections liable to have gout as their origin—and asked as to the possibility of his being gouty, nearly always repudiates the idea at once, and from a two-fold ignorance. Nearly everyone when he hears the word gout mentioned, at once associates it with the red-hot-great-toe gout which is now, I maintain, dying out to be replaced by a number, Protean in their variety and variability, of minor manifestations of the disease, presenting themselves on a very much smaller scale, and with characteristics much less easily diagnosed, but manifestations of gout for all that. What practitioner sees many cases of acute podagra now? It is passing away with the old-fashioned foot-rest, which used to accompany the convivial owner out to dinner, entailing his sitting, as some of us may remember, at the corner of the table. I remember, five-and-forty years ago, such a foot-rest being always sent on in advance to my father's house at Oxford, by one of the heads of the colleges.

Another reason for our being often baffled in our diagnosis of gout, as it presents itself to us at the present time, is that most patients associate gout with surfeiting and self-indulgence of all kinds, especially rich living. They argue as if in eating and drinking we were still treading in the footsteps of Dr. Johnson and Dr. Porson. Johnson, whose taste in port wine was such, that on some one venturing to remonstrate with him on the quality of his beverage, the great man replied, "Well, sir! it's thick, and it's sweet, and it makes you want to drink. What more do you want?" Porson, one of the greatest sons of Cambridge, one of the greatest of Greek scholars, and yet so addicted to strong waters, that on one occasion, after the early dinner of the day, he was put to bed in a condition of hopeless drunkenness, about half-past two, and yet at seven he was at an evening party given by the Master of Trinity, repeating to the fairest women in the room Pope's "Rape of the Lock" from end to end, without a hitch, by aid of his stupendous memory, and with explanatory annotations of his own.

V. *Hurry in diagnosis.*—Hurry is perhaps at the root of three-fourths of the mistakes which we make in diagnosis, hurried observation, hurried interpretation, hurried administration of drugs. But it is to an especial, and the worst form of hurry, to which I now allude. Early this evening I spoke of that pride in being thought skilful in diagnosis which leads men to publish only their successes, and to conceal and forget as soon as may be their mistakes. Another form of pride there is which takes its standpoint on rapidity of diagnosis, rapidity being only another name for hurry. A few hurried questions are put, and the opinion is straightway formed and as quickly announced. Any further examination is usually devoted, not to finding out facts as they really are, but to coloring or to twisting facts so as to suit the hastily formed, and as incautiously announced diagnosis.

The man given to hurry, or to the habit of "cocksuredness," fails to make allowance for the unexpected, which happens to us more often than in other professions.

Let such recall the advice of Bacon, who advises "not to engage a man's self peremptorily in anything, though it seem not liable to accident, but ever to have a window to fly out at, or a way to retire. Following the wisdom in the ancient fable of the two frogs, which consulted when their plash was dry whither they should go; and the one moved to go down into a pit, because it was not likely the water would dry there, but the other answered, 'True, but if it do, how shall we get out again?'"

And now, Gentlemen, I must occupy your time no longer. There is probably no one in our profession more absolutely free from neuroses than I am, but many have been the sinkings of the heart while I have been preparing and delivering these remarks. None, believe me, know better than I do, how unworthy is my offering of this hour, this audience, and this place.

I finish as I began. I am here to-night not because I am in any way worthy to follow those, who, on such a day as this, have stood here before me. I only happen to be here to testify to an ancient friendship. Under that

friendship I shelter myself, and for the sake of that friend I ask you to overlook my shortcomings.

You all of you know how your gain here in Manchester has been our loss in London. You know your President's many sidedness, whether as an operating or consulting surgeon, or as your representative in that chair; and lastly, but not least, to some of you he is known as a sportsman. And in all, the quality of his metal is known also. I will only add for myself that a truer, warmer heart I have never known; a better, more unpretentious specimen of the English gentleman I have never met.

I must say no more, for I agree with the ancients that "one should not sacrifice to one's heroes till after sunset." That the setting of that genial, cheery sun may be very long deferred is, I am certain, nowhere more earnestly desired than by the Medical Society of Manchester.

Appointments.

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Medical Council and approved by the House Committee:—

Clinical Assistants.—Messrs. W. F. Box, E. G. Goldie, P. A. Peall, C. H. Reinhold, F. H. Wallace, J. Goss.

Obstetric Dressers.—Messrs. A. E. F. Kynaston, C. J. S. Dismorr, O. V. Payne, J. Mc. F. Pollard (October 1st); F. B. Lowe, A. M. Benett, A. V. Maybury (November 15th).

Dressers in the Throat Department.—P. P. Cole, H. H. Carter, H. F. Bell Walker, T. C. Lucas, D. R. Pike, G. A. Ticehurst.

Clerk in the Throat Department.—Mr. R. M. Rendall.

Assistant Surgeons' Dressers.—Messrs. J. A. C. Greene, C. W. R. Preston, R. W. Allen, M. de L. Robinson, S. D. Jacobson (Mr. Lane); A. B. O'Brien, H. C. Cameron, F. D. Crew, R. E. French, G. H. Macalister (Mr. Dunn); V. A. P. Costobadie, A. D. Crofts, G. F. Greening, R. D. Barron, M. McPherson (Sir Alfred Fripp); N. H. Oliver, H. M. Langdale, W. C. McN. Dickey, A. H. Miller (Mr. Steward).

Medical Ward Clerks.—Messrs. G. Hamilton, W. P. Purdom, E. H. Adams, E. Bellingham Smith, R. J. Bentley, H. S. Knight, M. Leckie, E. F. Milton, H. A. Watney, F. T. H. Wood, B. B. Metcalfe, A. Morris, T. Norman, R. S. Harper, E. E. Rendle, G. N. Nicholson, R. M. Wingent, G. N. Bartlett, T. H. Barton, A. G. Jones, L. H. Burner, W. H. S. Burney, I. R. Cook, T. R. Harvey, H. H. Moyle, E. White, P. C. Litchfield, J. H. Mayston, G. H. Morris, C. F. Fothergill, H. G. Gibson, A. S. Morton Palmer.

Assistant Physicians' Clerks.—Messrs. T. C. Pocock (Dr. Shaw); F. A. Sharpe, H. F. Wight (Dr. Bryant).

Surgical Ward Clerks.—Messrs. E. M. Harrison, E. C. Lowe, E. Alban, A. W. Berry, A. W. Eyles, P. F. McEvedy, W. H. Miller, E. L. R. Norton, C. C. A. de Villiers, T. F. Wilson, P. S. Mills, E. Morgan, C. M. Ockwell, S. Reader, G. G. Timpson, W. H. Trethowan, G. Wacher, A. Walker.

Assistant Surgeons' Clerks.—Messrs. C. W. Greene (Mr. Lane); T. B. Layton (Sir Alfred Fripp).

CIVIL.

DAVY, HENRY, M.D., F.R.C.P. Lond., M.R.C.S. Eng., has been appointed Honorary Consulting Surgeon to the Winsford Cottage Hospital, Beaworthy, Devon.

GARNER, W. L., M.B., B.C. Camb., has been appointed Medical Officer of the Ampthill Union Workhouse.

SELLS, C. J., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer of the "Scattered Homes" of the Guildford Union.

STEWART, W. G., M.B., B.S. Lond., has been appointed District Medical Officer of the Ware Union.

NAVAL AND MILITARY.

Surgeons PERCIVAL M. MAY and ARTHUR S. KELSEY, R.N., have been appointed to the *Diadem* and *Scylla*, respectively, for passage home.

Colonel W. EGERTON SAUNDERS, C.B., R.A.M.C., Principal Medical Officer, Poona District, officiates as Principal Officer, Bombay command, pending the appointment of a permanent successor to Surgeon-General Price.

Captain W. G. BEYTS, R.A.M.C., has been ordered to the Punjab, and Captain C. M. FLEURY, R.A.M.C., is posted to Salisbury Plain.

Mr. A. E. BOYCOTT, M.A., M.B., B.Cl., B.Sc. Oxon., has been appointed Gordon Lecturer in Experimental Pathology at Guy's Hospital Medical School in succession to Dr. E. W. Ainley Walker, resigned.

NURSES.

Miss EDITH K. BLAYNEY has been appointed Ward Sister at the Royal Victoria Hospital, Belfast. She was trained at Guy's Hospital and holds the L.O.S. Diploma.

Miss ALICE BRIERLEY has been appointed Nurse-Matron to the Liskeard Cottage Hospital. She was trained at Guy's Hospital, London, and has since been Matron at Tetbury Cottage Hospital and Matron at the West Highland Cottage Hospital, Oban.

Miss KATE RAY has been appointed Nurse-Matron to the Tavistock Cottage Hospital. She was trained at Guy's Hospital, and worked at the Fulham Fever Hospital, and later held the posts of medical sister, surgical sister, home sister, and night sister at the Seamen's Hospital, Greenwich.

Passim.

THE alterations in the Dining Hall are slight, but improving. The gangways are carpeted, the woodwork of the windows is whitened, showing up the somewhat inartistic shape of the windows, and the walls have been retouched. The smoking-room has been cleaned and improved, and there is little room now left for criticism except the abominable grates and the carpets.

THE ingenuity of the authorities in providing prepared surfaces for smokers to strike on as they leave the dining hall, instead of the wall, deserves mention and approval. The Dinner on October 1st, will be in the dining hall, and a large attendance is expected. The President, P. H. Pye-Smith, Esq., F.R.S., will be in the chair, and Mr. Robert Gordon, a well-known and generous donor to the hospital and school funds, will be the guest of the evening.

THE forecast of the future of the London University in another column reminds one of Artemus Ward's note, "This is writ sarcastik," but it may none the less perhaps contain a good deal of truth.

That this will solve the difficulty of the degreeless "Conjoint" man is only too likely, and that it will lead to a greater diffusion of London graduates can be regarded as almost certain, but it will involve an easier trial before the examiners, and necessarily a fall in the standard. As regards ourselves, if the scheme is carried out, we can only gloomily prophesy that there will be no students here in their first three years sufficient to enable the hospital classes to be held; the dissecting-room will be bare and deserted, the athletics will suffer grievously, the ward clerks will be lacking in *esprit de corps*, and the traditional camaraderie will even not flourish so readily, but probably the London University coffers will profit by the increasing entry.

There is an ingenious suggestion in a recent number of the *Lancet* to avoid the invidious distinction that is often drawn somewhat pedantically between a medical man and a doctor. There are those who affirm that only a Doctor of Medicine is a doctor, and those who insist that the licensed apothecary is not a doctor. Meanwhile, the undiscerning public is perplexed, and not infrequently their indecision casts an unfair slur on their medical neighbours. Technically no medical man is a doctor except he be a Doctor of Medicine, or by courtesy a Bachelor of certain ancient seats of learning. Practically all general practitioners are doctors. The suggestion is that qualification should confer the right to the title of Doctor, and that the additional qualifications, if any, should customarily be added, so that the doctor's title will be generally conceded, and the degree equally emphasised. Thus the surgeon will become Dr. Smith, M.S. Lond., F.R.C.S.E., the physician, Dr. Smith, M.D. Camb., F.R.C.P., and the general practitioner, Dr. Smith, M.B. Lond., or Dr. Smith, M.R.C.S. It seems an ideal method, but while we recognise the ingenuity of the idea we appreciate the clumsiness of the title, and fear it will not find favour. At the same time, out of courtesy all men address their colleagues, of whatever degree, as Doctor in front of the laity. Do not the physicians invariably honour the H.-P. with the title of M.D.?

AN unwearied contemporary, keenly alive to the morbid taste of the public in medical matters of scant delicacy, as in the recent Carlyle controversy, has opened its columns to a discussion on the girl of the present day, and the usual divergence of opinion has been noticed. All medical men cannot but have noticed the increase in gynæcological practice among girls of the present day, and there must be a strong consensus of opinion that it has coincided in a marked degree with the great athletic efforts of girls and the strain they have so willingly undertaken. In fact, the improvement in general physique so noticeable among girls and boys of the upper classes has not been accompanied by a corresponding freedom from

ailments, and it is our strong opinion that the unwearied athlete who cycles, plays tennis, hockey, and other violent exercise, too often overdoes it, and then the after-history of athletic girls of the best type is often one of ill-health.

THE passing of the old-fashioned family doctor is a change in the direction of progress that all will lament. In the place of the friend, counsellor, and expert constitutional adviser, has sprung up the smarter, up-to-date diagnostician, who nevertheless has lost in solidity and reliability what he has gained by his *fin-de-siècle* theories. When the family had but one adviser, they were fain to study his convenience. Families abound each member of which employs a different adviser and changes them with the latest fashion—not in any spirit of disgust or want of confidence, but out of a restlessness that looses sight of the value of experience in the fascination of an exploration of the unknown. *Omne ignotum pro miraculo*, the youngest and most portentous must be the wisest. With this has come the cult of the specialist to an unheard of extent. Many who have leisure and means wander up and down Harley Street and Cavendish Square, dropping guineas as they go, obtaining interviews with charmingly-mannered men whose superficial diagnosis is only too true, that either there is nothing the matter, or if there is, it cannot be fathomed in the limited time at their disposal. The sorrow is that the genuine consultant of wide hospital experience and sound pathological training is but dimly discerned amid the throngs of flourishing physicians wielding the "high frequency" switch, equally with the latest fat cure.

IT is to be hoped that the public will realise that a skilled observer in touch with men of recognised position as consultants is the cheapest and most reliable combination for ordinary life, and that in the multitude of counsellors there is foolishness. Consider the cult of the age. How many refractions are treated by prescribing opticians to the damage, often lasting, of the confiding and wealthy public. How many "treatments" or "cures" are daily practised that any respectable hospital physician would condemn, and, *per contra*, how frequently one finds a keen insight to a case, an early diagnosis has ensured a safe recovery from great danger because it has been early avoided, and yet this service ill-requited because unrecognised.

Our Doctors.

He must not walk his rounds, for fear his patients think
  him poor,
For dearly do they love to see a carriage at their door;
And if his horse is fat he must have little work to do,
And if 'tis lean the reason is he starves that poor old
  screw.
If he calls upon his patients every day when they are ill,
The reason is he wants to make a great big doctor's bill;
If he calls on them less frequently, thus lessening their
  expense,
The chances are he'll be accused of wilful negligence.
About his own afflictions he must never say a word—
The notion of a doctor being ill is too absurd!
And when perhaps from overwork he's laid upon the
  shelf,
His sympathising patients say "Physician, heal
  thyself!"

—*Westminster Hospital Gazette.*

Change of Address.

Dr. G. N. P. Carrell has removed from 51, Woodland Road, to 34, The Drive, Ilford, Essex.

Dr. J. Farrant Fry from Shepton Mallet, to 13, Dane Road, St. Leonards-on-sea.

Dr. A. Kinsey-Morgan from 1, Stanhope Gardens, to "Hillcote," Richmond Hill, Bournemouth.

Dr. W. L. W. Marshall from Oak House, to Vernon House, New North Road, Huddersfield.

Dr. W. Harland Peake from No. 11, to Homefield, 1, Platt's Lane, Hampstead, N.W.

Dr. F. Douglas Turner from No. 54, to Oak House, New North Road, Huddersfield.

Dr. J. A. Wood from 9, Buckingham Place, to 9, Saville Place, Clifton, Bristol.

Dr. Walter C. C. Pakes from Pretoria to the Government Laboratories, P.O. Box 1080, Johannesburg, South Africa.

Dr. W. E. Sturges-Jones from 1, Sternhold Avenue, Streatham, S.W., to "Deloraine," Half Moon Lane, Herne Hill, S.E.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Lectures* for Sessions 1903–1904.

WINTER SESSION. OCTOBER—MARCH.

†	Lecturers.		Days.					
Anatomy (1st & 2nd)	Mr. Lane and Mr. Dunn	9	—	Tu	W	Th	Fri	—
Microscopical Pathology (3rd) ...	Mr. G. B. Smith and Dr. Eyre ...	9	—	Tu	—	—	Fri	—
Pathological Classes (3rd & 4th)	Dr. Fawcett and Mr. Steward	9.15	—	—	W	Th	—	Sat
Bacteriology (Oct. & Nov.) (4th)	Dr. Eyre	4	—	Tu	—	Th	—	—
Practical Obstetrics (3rd & 4th)	Mr. Hicks (Oct.)	—	—	Tu	—	—	—	—
Chemical Physiology (Jan.) (2nd)	Dr. Pembrey, Dr. Forsyth & Dr. Spriggs	11	—	—	—	—	Fri	Sat
Biology and Botany (pre. sci.)...	Dr. Stevens	2	—	—	W	—	Fri	—
Chemistry (1st and pre. sci.) ...	Dr. Wade	12.15	—	Tu	—	Th	—	—
Practical Chemistry	Dr. Wade, Mr. Ryffel and Mr. Ball ...	10-12	—	Tu	—	Th	—	—
Advanced Practical Physiology (3rd)	Dr. Pembrey	11	M	—	W	—	—	—
Practical Medicine (3rd) ...	Dr. French and Dr. Barber	12.30	—	—	—	Th	—	—
Experimental Physics (pre. sci.)	Professor Reinold and Mr. Ball ...	12	M	—	—	—	Fri (2)	—
Chemical Physics (1st)	Professor Reinold	2	—	—	—	—	Fri	—
Practical Surgery (3rd)	Mr. Simpson	12	—	—	W	—	Fri	—
Physiology (2nd)	Dr. Pembrey (Oct.-Dec.)	10	M	—	W	—	—	Sat
Clinical Medicine (3rd & 4th) ...	The Physicians	1	—	—	—	—	—	Sat
Surgery (3rd)	Mr. Lucas and Mr. Golding-Bird ...	9·30	M	—	W	Th	—	—
Clinical Surgery (3rd & 4th) ...	The Surgeons	1.30	—	—	W	—	—	—
Elementary Biology (1st) ...	Dr. Stevens and Mr. Turner	2	—	—	W	—	Fri	—
Mental Physiology (Oct. & Nov.) (3rd & 4th)	Dr Craig	2	M	Tu	—	Th	—	—
Morbid Anatomy (3rd & 4th) ...	Dr. Bryant and Dr. Fawcett	2	M	Tu	W	Th	Fri	Sat
Medicine (3rd)	Dr. Taylor and Dr. Hale White ...	4	M	—	W (3)	—	Fri	—
Ophthalmic Surgery (Jan.) (4th)	Dr. Brailey	4	—	—	W	—	—	—
Public Health (Jan.) (4th) ...	Dr. Sykes	4	M	—	—	—	Fri	—
		—						
Dental Surgery and Pathology...	Mr. Newland-Pedley	4	—	—	—	Th	—	—
Metallurgy	Dr. Wade	4	M	—	—	—	—	—
Practical Dental Metallurgy ...	Mr. Hopson (Jan.)	3.30	—	Tu	—	—	—	—
Dental Anatomy & Physiology...	Mr. Maggs	4.30	—	—	W	—	—	—
Dental Mechanics	Mr. Wynne Rouw (Oct.–Dec.)	4	—	Tu	—	—	—	—
Practical Dental Mechanics ...	Mr. Pillin (Jan.)	2.30	—	—	—	—	Fri	—

SUMMER SESSION. MAY—JULY.

†	Lecturers.		Days.					
Medical Jurisprudence (3rd & 4th)	Dr. Stevenson	10	—	—	W	—	Fri	—
Midwifery (3rd)	Dr. Horrocks and Mr. Targett	9	—	Tu	W	Th	—	—
Diseases of Women	Dr. Horrocks and Mr. Targett	9	—	—	—	—	Fri	—
Pathology (3rd)	Dr. Pitt	9	—	—	—	—	—	Sat
Mental Diseases (3rd)	Dr. Craig	9.30	M	—	—	—	—	—
Bacteriology (May & June) (4th)	Dr. Eyre	4	—	Tu	—	—	Fri	—
Practical Obstetrics (3rd) ...	Mr. Hicks	—	—	Tu	—	—	—	—
Biology and Botany (pre. sci.) ...	Dr. Stevens	2	—	—	W	—	Fri	—
Physiology (2nd)	Dr. Pembrey	11	M	—	W	—	—	Sat
Histology (1st)	Dr. Pembrey, Dr. Spriggs and Dr. Forsyth	9	M	—	W	—	—	Sat
Practical Medicine (3rd) ...	Dr. French and Dr. Barber	12.30	—	—	—	Th	—	—
Experimental Physics (pre. sci.)	Professor Reinold and Mr. Ball ...	12	M	—	—	—	Fri (2)	—
Clinical Medicine (3rd & 4th) ...	The Assistant Physicians	1.30	—	—	W	—	—	—
Clinical Surgery (3rd & 4th) ...	The Assistant Surgeons	1.15	—	—	—	—	Fri	—
Morbid Anatomy (3rd & 4th) ...	Dr. Bryant and Dr. Fawcett	2	M	Tu	W	Th	Fri	Sat
Materia Medica (2nd)	Sir Cooper Perry	4	M	—	W(3)	—	Fri	—
		—						
Operative Dental Surgery ...	Mr. Badcock	9	—	—	—	Th	—	—
Chemistry	Dr. Wade	12.15	—	Tu	—	Th	—	—
Practical Chemistry	Dr. Wade, Mr. Ryffel, and Mr. Ball ...	9	—	Tu	—	Th	—	—

* No effort has been made to include the many demonstrations or practical work.

† The numbers in this column refer to the years in which this course should be attended.

The Sciences.

ANATOMY AND THE DISSECTING ROOM.

How to begin Work.

THE first working day spent at Guy's Hospital is always a memorable event. There is a feeling of strangeness, which is quite natural. We are but vaguely conscious of what is to be done, and blissfully ignorant how to set about it. The very names of the subjects we have been told to learn convey no meaning, and the school buildings, with their various class-rooms and theatres, are an unexplored country through which we travel as in a maze.

For the help of the new men, it is proposed to give such instructions as they may need in beginning the work of their first winter session at Guy's. It will be assumed that they have already decided what the general course of their study is to be, that is briefly; whether they are going in for the Preliminary Scientific Examination of the London University or not. Information on these matters is readily obtained at the Medical School Office, and any student who is not clear in his mind as to the examination he has to prepare for, should read carefully page 72 in "the green book."

After the first few days men soon become familiar with the work, and learn from one another. But at first they have made no acquaintances, and all around them are strangers alike.

Under the Five Years' Regulations of the Conjoint Board, the first object of the student (entering, for instance, in October, 1903) is to pass the examinations in Chemistry and Biology, as failure to complete these by the following March (*i.e.*, 1904) must postpone the date at which the Second Conjoint should be passed (*i.e.*, April, 1905), *vide* par. 6, p. 402, so that students are advised, unless they have passed either one or both of the above subjects before entering the hospital, or are unusually well versed in the subjects for these examinations, to postpone dissecting until one or both (Chemistry and Biology) have been completed.

What follows refers, therefore, only to those who intend to undertake their dissections at once.

Thursday, October 1st.—There is no actual work done on this day, but each student who is ready to dissect (*vide supra*) should pay his fee, *vide* par. 2, p. 402, for anatomical material in the Medical School Office, and take the receipt across to the dissecting-room and present it to the demonstrators. He should then study the red book—which contains the rules of the dissecting-room—and purchase the necessary instruments and the other paraphernalia therein indicated. Any spare time is well spent in learning where the museums, class-rooms, and theatres are situated. The ground plan at the front of the "green book" will show them at a glance, and serve as a very efficient guide.

Friday, October 2nd.—At 9 o'clock in the morning the start is made, and we get our first introduction to the duties of hospital life at a lecture by Mr. Lane in the anatomical theatre, and at 12 o'clock a demonstration is given to all first year's men by the Senior Demonstrator (Mr. Fagge) in the small theatre attached to the dissecting-room, both of which every new student is expected to attend.

To find a "Part."

Look down the list of names on white cards which are suspended upon the wall of the dissecting-room opposite each subject or body. Be careful to take the proper side (right or left) which is allotted to you. If you fail to find your name on these cards, make yourself known and report the fact to one of the demonstrators present, who may be recognised by his white coat. The next thing is to obtain a bandage and cloth from the attendant (Hancock), who will be found in a room outside the dissecting-room. With these the "part" must be covered up at once to prevent the skin from drying. If the "part" is a limb, bandage it firmly from the hand or foot upwards as far as the bandage will go, and cover the remainder with a cloth, *but be careful to leave the metal ticket exposed to view.*

The Requisites for Dissection.

The following articles are essential, and must be purchased at once:—

a. Case of instruments. This should contain at least four knives, forceps, scissors, hooks, needle and blowpipe. Price 15s. to 20s., at Messrs. Down Bros., of St. Thomas's Street; or at Messrs. Hills & Co., of Newcomen Street; also from Hancock, the dissecting-room attendant.

b. Books. These are obtainable at Grattan's in the Borough, next door to the post-office. It is advisable to obtain *Cunningham's Practical Anatomy* (2 vols. 9s. 6d. each) for use in the dissecting-room, which show how to proceed and what is met with in the course of dissection; *and* one at least of the standard text-books, viz., Gray, Morris, Quain, or Cunningham's Text Book. The inquirer will hear their merits compared at the introductory lecture and demonstration; if still in doubt he should consult personally one of the demonstrators, and take with him any old text-book he may possess for inspection and advice as to its use.

c. An apron and sleeves for the sake of protection and cleanliness. These are sold by Hancock. Any old coat may be worn under them. Instruments, books, apron and coat must be safely put away in a locker provided for the purpose; the key is obtained by making a deposit of 5s. at the Medical School Office. During the day hats and coats are kept at a special cloak-room near the dissecting-room.

d. A disarticulated skull and a half skeleton. (*See below*).

With regard to all the necessary articles mentioned above in *a b* and *d*, it is well to point out to new students that many men who have just completed their anatomical studies may wish to dispose of some of the above articles second-hand, and new students may obtain information about, and details of such things

to be bought, from the librarian, Hancock, or the commissionaire, with whom such things are usually lodged. Before completing any such purchase it is always best to make sure that the books are of the last edition published and that the instruments are reliable, points on which any of the demonstrators will gladly give advice.

How to Dissect.

The instructions given on this point in the text-books are by no means clear to one who has never done any dissecting in his life, and who does not know the meaning of half the scientific words in which the directions are given. He finds quite a new language in use, and no translation of it in the margin. Thus, he is told to "make an incision," instead of "cut"; to "reflect the integument," for "turn back the skin"; "anterior and posterior," instead of "in front and behind." Not a little of the difficulty and dulness attaching to anatomical description depends on the need of a mental translation of the language in which they are written.

To deal fully with the skilful act of dissection is unnecessary here, and we will merely give such short directions as are needful for the work of the first two or three days. The objects of dissection are—firstly, to educate the sense of touch, and to teach the hand and the eye to work together in delicate manipulation; and secondly, to enable the student to see and handle the different structures that he reads about in his books. It is most decidedly not the object of dissection to lay bare the bone in the middle of the "part" in the shortest possible time. That is butchery, not dissection. The following advice, then, may be given:—

1. Take your book (Cunningham) by which you intend to dissect and read over the pages giving directions for the skin incisions to be made in that particular part you are about to dissect.

2. Cut through the skin along the lines given in the books.

3. Turn back *the skin only*, leaving the fat upon the body. This is done by holding the knife obliquely with its edge towards the skin.

4. Take away the fat carefully without damaging the dense white layer which covers the muscles.

5. Clean the surface of the muscle. To do this make the muscle taut by moving the limb, or pulling on it with hooks; then with the point of the knife clear away everything covering the muscle by working *with* its grain or fibre, *not* across the fibres.

6. Before taking any fresh step in your own dissection get a notion of the arrangement of the parts you are going to expose, either from another man's part, or from the "pickle room," or wax model museum preparations. *Most important of all, never remove any structure until you have obtained a good mental picture of it, and have also read in your book the description of it, and have satisfied yourself you know it.*

7. Work very slowly at first. To turn back the skin carefully is quite enough to occupy the first day's work-time.

8. Cover the "part" up with a cloth before leaving it for the night.

The red book containing the rules of the dissecting-room will be found to contain a lot of useful information, which we give in full below, and should be read with are, and then kept always at hand.

Osteology.

Usually considered a very dry subject; hence commonly studied in a stuffy museum after a heavy lunch with—the usual result. Like other branches of anatomy it must be learned practically—by handling the bone, reading the description of it, and noting the various marks upon it, each one of which has its meaning. In order that the bones may be studied at home as well as at the hospital, it is very important that each student should possess them. Half-sets of osteology, that is, the bones of one side of the body with the spine and head, can be obtained second-hand at a very moderate outlay, and if carefully used they will at the end of the course readily fetch half the original cost, or even more. Some very useful half-sets (second hand) are to be seen at Messrs. Millikin & Lawley's, 165, Strand, W.C., price 30s. If these are disposed of at the end of the second Conjoint examination for half the price, it follows that the immense advantage of having the bones always at hand while preparing for the examinations is obtainable at the expense of a few shillings.

In selecting a half-set of osteology it is as well to have the guidance of a fellow student who is familiar with them. See that the half-set is complete, and that each bone is of the *same* side. Avoid "the nice white bones," which dealers always charge extra for, and choose the rougher, better marked and dirtier ones. The preparation which makes them white, does away with many of the marks and ridges which have to be studied. With regard to the disarticulated skulls, try the separate bones and see whether they fit into each other properly, as it is not uncommon to find skulls offered for sale, the bones of which have come from different subjects, and hence cannot be articulated.

It may be necessary now that the Elementary Anatomy examination has been done away with at the College, to caution men against neglecting the subject during their first year. They will find the second year's work quite heavy enough as it is, and moreover may suffer the mortification of being spun in the school elementary anatomy examination at the end of the first winter session, if they neglect the bones in their first month's work.

Rules of the Dissecting Room.

1. All first and second year's students, and all those senior to the second year, who have not passed the Second Conjoint Examination, are expected to attend in the dissecting-room on the first day of the Winter Session, between the hours of 1 and 4 p.m., or on the second day between the hours of 10 a.m. and 12 noon. Each student must bring with him a voucher indicating that he has paid the special fee for material, which voucher must be handed to the demonstrator in order

that the student's name may be enrolled in the appropriate class list.

2. The fee for material (which should be paid in the Medical School Office on or before the first day of the Winter Session, between the hours of 10 a.m. and 1 p.m.) is—

For each academic year:—

First Year's Students	25/-
Second Year's Students	
Students Senior to the Second Year but not yet through the Second Conjoint Examination	

For each three months:—

Students who have passed the Second Conjoint Examination and are preparing for any later examination	10/6
Students for the L.D.S. Examination only	

3. The senior demonstrator (Mr. Fagge) will meet the first year's students on the second day of the Session at 12 noon, and give them a demonstration to initiate them into the work of the dissecting-room. Immediately after this demonstration parts will be allotted to students.

4. On the following day the bone classes, which are held by Mr. Rowlands and Mr. Turner, begin. Every student is advised to purchase a half skeleton and to bring to the class the bone or bones which will form the subject of the demonstration. Regular attendance at these classes is compulsory until a student has passed in Elementary Anatomy. A student attending the class that is studying (A) or (B), in Rule 8, will be allotted a part corresponding with the work of the class.

5. The senior demonstrator will meet the second year's students on the third day of the Session. The Second Year Class demonstrations given by Mr. Rowlands and Mr. Turner begin early in the following week.

6. No student shall be enrolled in the Second Conjoint list or allowed to begin dissecting as a second year's student until he has passed in Biology and Chemistry at the First Conjoint Examination and the School Examination in Elementary Anatomy.

7. The notice-boards in the dissecting-room should be examined daily throughout the Session. Here will be found class lists, notices of allotment of parts, announcements of vacancies for prosectors, arrangements for examinations, etc., and notices of alterations in standing arrangements. Every student's name should appear in one of these class lists, and any student failing to find his name should at once inform one of the demonstrators.

8. A written examination in Anatomy is held just before the Christmas vacation. Every first year's student, whether medical or dental, is required to attend and to answer the questions on one of the following groups;—

(A) The bones and ligaments of the head, and the bones, ligaments and muscles of the upper extremity; or

(B) The bones and ligaments of the spinal column and thorax, and pelvis, and the bones, ligaments, and muscles of the lower extremity.

Every second year's student is required to attend and to answer questions on—

The muscles, tendons, bones and ligaments of the whole body; and one of the following groups—

(α) The entire anatomy of the upper extremity and of the head and neck, including the brain and spinal cord; or

(β) The entire anatomy of the lower extremity and of the abdomen, pelvis and thorax: or

(γ) (*if he is taking the L.D.S. only*) The entire anatomy of the head and neck, excluding the brain.

9. The dissection of all parts allotted in October and November must be completed before Christmas, and on the second day after the recess new parts will be allotted, priority being given as far as possible to those students who showed themselves most painstaking in their previous work. A first year's student who, before Christmas, studied sub-division (A) in Rule 8, will now study sub-division (B): but in addition every student should, in this his second part, try to master as much as possible of the vessels, nerves, etc.

10. A school examination in Elementary Anatomy on the bones, ligaments, and muscles of the whole body, is held four times a year, in March, July, October, and December; this must be passed by every one before he is allowed to commence the recognised period as a "second year's" student.

11. The senior demonstrator holds (i.) classes throughout the Winter and Summer Sessions for students preparing for the First F.R.C.S. and M.B. Examinations of the various universities in general advanced Anatomy and in Embryology. (ii.) Revision Classes before each of these Examinations. (iii.) Revision Classes for students who, though they have completed their second year, have not yet passed the Second Conjoint Examination.

12. Every student is advised to carry with him when in the dissecting-room and demonstration theatre a pocket note-book and a set of coloured chalks.

13. Every week the dissections are examined systematically by the demonstrators, and marks are allotted. Each student's diligence in the dissecting-room is taken into account in subsequently recommending to appointments in the wards.

14. A test examination is held three weeks before each Second Conjoint Examination. Attendance at this examination is compulsory on all those who wish to present themselves for the Conjoint Examination.

15. Particulars of the examinations for the Michael Harris, Arthur Durham, and Hilton prizes, and for the prizes for General Proficiency will be found in the Prospectus of the Medical School, which may be obtained in the Medical School Office.

16. About twelve prosectors to the lecturers on Anatomy are appointed annually (and from time to time a prosector to the Royal College of Surgeons of England) from among those students who have shown themselves most diligent in the dissecting-room. Notices inviting

applications for these appointments are posted in the dissecting-room.

17. The metal ticket attached to each part must on no account be allowed to come off nor to be covered up by the bandage that each student should apply to his part (if a limb); neglect of this rule renders the part liable to be forfeited. Apron and sleeves (2s. 6d.), bandages, cloths, air-pump, ointment, carbolic lotion, etc., can be obtained from the dissecting-room porter.

18. No muscle, tendon, nerve, artery, or large vein, should be cut through, if by hooking it aside it is possible to reach and clean the parts lying on its deep surface.

19. No limb must be removed from the trunk except by one of the demonstrators or assistant demonstrators, nor in any circumstances must any part of a subject be removed from the dissecting-room.

20. Except when the student responsible for a part is actually at work upon it, each part must rest constantly on the table of the subject to which it belongs. Neglect of this rule renders the part liable to be forfeited. When a student considers he has finished the part, he must report the fact to one of the demonstrators.

21. The subject is divided into five parts on each side:—

1. The Head and Neck and Spinal Column.
2. Upper Extremity and Muscles connecting it with the Trunk.
3. Abdomen, with the Perinæum and interior of the Pelvis.
4. Lower Extremity.
5. The Thorax, the dissection of which is not to commence until the fourteenth working day.

22. Students are not permitted to exchange or dispose of their parts, either before or after the commencement of dissection.

23. Any part, the dissection of which has not been begun within twenty-four hours from the time when the body is placed in the dissecting-room, is liable to forfeiture. If a student is unable to continue the dissection of the part which he has already begun, he must give notice in writing to one of the demonstrators, who will make arrangements for its disposal. The demonstrators will also dispose of any part, the dissection of which has been discontinued without their sanction for more than two working days.

24. The subject when brought in will be placed in the supine position, and will so remain during nine working days. On the tenth day a majority of the students engaged upon it, and on the fourteenth day any one of them, may have it turned into the prone position. Five days later it may, if the majority so desire, be turned back again; and after six days in the prone position any one of the dissectors may have it turned back. The time for the dissection of the perinæum is before 11 a.m. on the first ten days, and neither for this purpose nor for any other must the subject be turned out of the position indicated in this rule.

25. The dissecting-room is open from 9 a.m. till 4·30 p.m., except on Saturdays, when it is closed at 2 p.m.

26. On applying at the Medical Office a locker may be obtained for a deposit of Five Shillings (which will be returned when the key is given up, provided that the locker is uninjured).

DENTAL STUDENTS.

A dental student, on entry, must pay the fee (10s. 6d.) for material at the Medical School Office, on October 1st, between 10 a.m. and 1 p.m., so that a part may be allotted to him at the earliest opportunity. He should obtain a copy of the rules of the dissecting-room, and study those paragraphs which specially concern him. He should be careful not to miss the demonstration given by Mr. Fagge to first year's students, on Friday, October 2nd, at 12 noon.

It is very important for first year's dental students to commence their anatomical studies without delay. During their first six months they should dissect the upper and lower extremities, and attend the bone classes held by Mr. Rowlands and Mr. Turner throughout the winter and summer sessions. They should pass the school elementary anatomy examination at the end of their first six months if possible, or failing this, not later than nine months from their entry at the hospital. The subjects of this examination are:—

1. All the bones and ligaments.
2. The muscles and fasciæ of the upper and lower extremities.

Having passed the elementary anatomy examination, dental students are allotted a head and neck, in which they are expected to dissect, besides the muscles and ligaments, the vessels, nerves, and other soft parts, and also to acquaint themselves with the anatomy of all the special regions of this part, *e.g.*, the orbit, mouth, pharynx, etc.

Mr. Rowlands holds anatomy classes for these students, throughout the winter session, in the dissecting-room theatre, on Thursdays, at 1.30 p.m., and a test examination is held on the work at the completion of the dissection and the course of demonstrations. It will be agreed that the second dissection is even more important than the first, and it is well to realise that, as the work done by each man is noted and marked every week by Mr. Rowlands, and men are only signed up for the necessary session's work when these marks are satisfactory, that careful and conscientious dissection, punctual attendance at demonstrations, and industrious reading up of all the work, must be begun as soon as the dental student enters the dissecting-room, and continued until the subject is mastered.

It is very essential that the study of anatomy, physiology, and surgery should be prosecuted energetically from the outset, thus obviating the necessity for "cramming" these subjects when preparing for the Final L.D.S. examination. Careful and patient dissection is the easiest way to learn Anatomy. An

attempt to "cram" it from books is certain to result in disaster.

PHYSIOLOGY.

Physiology, which treats of the working of the healthy body, and forms, therefore, the institutes of medicine and the necessary foundation of any rational mode of treatment of the body in disease, differs from its sister subject, Anatomy, in that it requires much greater intellectual efforts for its acquisition, and a more thorough preliminary training for the comprehension of its doctrines. Physiology consists chiefly in the application of the natural laws elicited by the researches of physicists and chemists to the explanation and description of the phenomena occurring in the living body, so that an acquaintance with the chief laws of physics and chemistry forms the necessary basis for the study of physiology. The study of the nervous system, moreover, requires some knowledge of psychology. The difficulty and importance of the subject would seem to indicate, in the clearest possible manner, the necessity of pursuing its study throughout the short space of two years, which are devoted to the subjects that are preliminary to the work in the wards. On this account, the student beginning his medical studies in October must give all his energies to getting up his biology in order to pass in it at the earliest possibly opportunity, and he may profitably combine with the biology lectures and classes the reading of some physiology, such as Starling's *Elements of Human Physiology*, or Halliburton's *Handbook of Physiology*, or the smaller work on the same subject by Foster and Shore. He is advised to attend the physiology lectures at this time, but cannot be "signed up" for them.

By the ordinary student the practical study of the subject included under the heading "Physiology" is begun in the first summer session. During the whole of this session he must attend the classes in Practical Histology. These are held in the students' histological class-room three times a week; each class lasts two hours. Students attending this course must provide themselves with a compound microscope,* certain mounting materials (a list of which can be obtained at the office), and with Schäfer's *Essentials of Histology*, which should be carefully studied in the intervals between the classes. The microscope must have two objectives, a $\frac{2}{3}$-inch and a $\frac{1}{6}$-inch, a nose-piece and an indicator fitted to one of the two eye-pieces. The following makers are recommended: Crouch, Zeiss, Ross, Leitz (English agent, Kanthack), Swift. From any of these latter firms a good microscope, with all necessary accessories, can be obtained for about £7; the microscope from inferior makers is worse than useless, for it is essential that the student should buy an instrument which will be of some use to him in future years, when as a practitioner of medicine he desires to examine tumours, urinary sediments, sputum, etc., for purposes of diagnosis.

* The demonstrators will be very pleased to advise any student in the purchase of a microscope. It must be distinctly understood that antiquated instruments, such as those sometimes handed down as an heirloom in a family of doctors, are practically useless.

At the end of the summer session an examination is held in histology. All students who have attended this class must enter for the examination. Only those who pass the examination will be allowed to attend the tutorial classes in physiology held during the second winter session in preparation for the examinations of the Conjoint Board. Those who fail at this examination will be examined in the following session.

During the first summer session and the first half of the second winter session the student should attend regularly the lectures on physiology held three times a week, on Mondays, Wednesdays, and Saturdays at 10 a.m. During the same time those who have passed the histology examination at the end of the previous session should attend the tutorial classes held by one of the demonstrators throughout the session. At the same time he should read up the subjects in some text-book such as Starling's *Elements of Human Physiology*, or Halliburton's *Handbook of Physiology*.

During the winter session, *i.e.*, from January to March, students must attend the classes in practical physiology, which are held on Friday and Saturday mornings from 11 to 1. From October to Christmas physiological chemistry is worked at in the room devoted to that subject. While attending this class, they are recommended to read up the subject in *Practical Physiology* (published by Arnold) which is used in the practical work. From January to March the class is held in the histological laboratory, where the student becomes practically acquainted with physiological apparatus, and performs simple experiments.

Students who have been diligent in following this course of studies will be ready to enter for the second Conjoint examination at the end of this session. Shortly before this examination, a test examination is held by the demonstrators in order to judge of the fitness of the candidates. Those who fail to pass the second Conjoint at this time must attend the revision classes held by the demonstrators during the two or three months preceding the July and January examinations of the Conjoint Board.

Certain modifications in this course of studies is necessary for those who are going up for the M.B. of London or other Universities. Having passed their preliminary scientific before entering, they are free from the study of biology during their first winter session. They should therefore attend the physiological lectures during this session, at the same time studying the subject in Starling's *Physiology*. In their first summer they attend the histology classes, and read Schäfer's *Essentials of Histology*. During their second winter, they should attend the class in advanced practical physiology, which is held twice a week, each lesson occupying between two and three hours. During this session they are recommended to read up the subject in Stewart's *Manual of Physiology* and Bunge's *Physiological Chemistry*, using *Practical Physiology* in the advanced practical work. This class should also be attended by candidates for the first

F.R.C.S. examination, although in their case attendance may often be profitably postponed until the third winter session. The reading for this examination is similar to that required for the Intermediate M.B. of London.

Those who are desirous of obtaining honours at the Intermediate M.B. should supplement the course of reading already indicated with original papers in the *Journal of Physiology* and with parts of Schäfer's *Text-book of Physiology*. Such students will also find parts of Foster's *Physiology* extremely useful and suggestive. University students should also attend the lectures given on Physiology at the London University.

Revision classes are held by the demonstrators during the two months preceding the first F.R.C.S. and first M.B. examinations for the special preparation of candidates for these examinations.

List of books recommended :—

FOR COLLEGE MEN.—Schäfer's Essentials of Histology; Starling's Elements of Human Physiology, or Halliburton's Handbook of Physiology; Practical Physiology, published by Arnold.

FOR UNIVERSITY MEN.—Stewart's Manual of Human Physiology; Bunge's Lectures on Physiological Chemistry; Embryological parts of Quain's Anatomy.

BIOLOGY.

The course of lectures and demonstrations for the requirements of students preparing for the first Conjoint examination is given in the long room, class-room No. 2, at 2 p.m., Wednesdays and Fridays. The practical class will be held immediately after the lecture, and the new student is reminded that it is most important for him to attend both lecture and practical class from the *very first*, to obtain the knowledge in biology requisite for the Conjoint examination. The very closest attention to his work, more especially *in the practical part*, is necessary if the pupil would become familiar with a subject which, seemingly of not much value to him now, will be of no inconsiderable assistance in later work, particularly in the domain of morbid histology and bacteriology.

The first lecture will be given by Dr. Stevens, in the long room, class-room No. 2, at 2 p.m., *October 2nd*. For the practical class, the requisites, of which a complete list is given below, must be obtained *beforehand*. We recommend new men, with reference to the purchase of a microscope—perhaps the most important consideration on entering these classes—that it should be deferred until one of the demonstrators has been consulted. We may state that microscopes are not absolutely necessary for the early classes, so that the purchase of one may be safely withheld until full instructions have been received from the demonstrators.

The special course of lectures and demonstrations devoted to the Preliminary Scientific examination of London are held on Wednesdays and Fridays at 10.30 a.m. The first lecture will be given by Mr. Assheton on Friday, October 2nd, in the theatre in the pathological museum block of buildings. "Pre. Sci." men will require the set of requisites that are notified below.

With regard to this list, we have already referred to the "microscope." In purchasing a "dissecting case," students must understand that an ordinary (human) anatomical set, with a pair of biological scissors and forceps in addition, is *all* that is required.

REQUISITES FOR THE PRACTICAL BIOLOGY CLASS

Every student attending these classes must provide himself with a microscope fitted with a double nose-piece. Crouch's student's microscope with ⅔rds and ⅛th objectives, two eye-pieces and a double nose-piece, in mahogany case, price about £7 10s., is strongly recommended. It can be obtained from Mr. Crouch himself, or from Maw, Son & Sons, Aldersgate Street. If a foreign pattern of microscope is preferred, Zeiss's or Leitz's is to be recommended, and can be obtained of Stanley, London Bridge; R. Kanthack, 18, Berners Street, W., or of Baker, 244, High Holborn. These microscopes are slightly more expensive than Crouch's.

It will also be necessary to have the following:—Three small white saucers with flat bottoms; three watch-glasses ground on convex surface; two section lifters; three needles in handles; a pair of microscope scissors; ½-oz. No. 1 ¾-inch cover glasses; a gross of glass slides; a packet of labels; a small piece of soft silk; fine curved forceps; a "Seeker;" an anatomical dissecting case; a razor for cutting sections.

HONOURS IN ZOOLOGY.

A special course will be given in Zoology for students who may desire to take honours in that subject, full particulars of which can be obtained at the office of the Medical School, or from Mr. Assheton. T. G. S.

CHEMISTRY AND PHYSICS.

It is impossible to acquire a knowledge of chemistry or physics without personal and practical contact with the experimental side of these sciences, and Guy's men have, in the roomy laboratories, unusual facilities for this purpose.

Conjoint men entering now should pass in chemistry and physics next Easter, and should therefore attend the lectures in chemistry from October to March (Dr. Wade Tuesday and Thursday at 12.15), and the lectures on physics from October to Christmas (Professor Reinold Monday at 12 and Friday at 2). They must be prepared to devote a large amount of time to laboratory work. The practical classes are held in the chemical laboratory twice a week (Dr. Wade, Mr. Ryffel, and Mr. Ball Tuesday and Thursday from 10 to 12), but students have access to their benches at all hours, and are advised to make free use of this privilege if they wish to make satisfactory progress. The first class of the new session will commence at *10 a.m. on Thursday, October 1st*, when *all Conjoint Students* should attend; the first lecture at 12.15 on Tuesday, October 6th. Revision classes are held before the April, January and July examinations; admission to these classes is dependent

on the student passing the test examinations in a satisfactory manner.

Dental students under the new regulations are required to go through the same course as the Conjoint men, and to pass the same (Preliminary Science) examination; they should attend the laboratory class at *10 a.m.* on *Thursday, October 1st.*

Special courses have been arranged for most of the University examinations. Candidates for the Preliminary Scientific (M.B.) examination of the London University attend the same chemistry lectures as the Conjoint men, and, in addition, the organic chemistry lectures on Wednesdays at 2. The physics lectures are continued throughout the sessional year (Professor Reinold, Monday at 12, Friday at 2). The Preliminary Scientific class meets for work four times weekly in the chemical laboratory, Dr. Wade, Mr. Ryffel, and Mr. Ball, winter and summer, Monday and Thursday, 2 to 4, Tuesday and Thursday 10 to 12), and twice weekly in the No. 1 physical laboratory (Mr. Ball: winter, Tuesday 2 to 4, Friday 3 to 4; summer, Monday and Thursday 2 to 4); *but students are expected to spend all their spare time in one or other of the laboratories.* It cannot be too often or too strongly urged that reading without laboratory work is mere waste of time. Tutorial classes are held weekly in both chemistry and physics, and are supplemented by revision classes during the term preceding each examination, and by periodical test examinations.

Intermediate M.B. men should begin to work at organic chemistry at once, and must pass the special examination in January or July, 1904, or they will have to take the Preliminary Scientific examination over again. The practical class meets twice weekly in the laboratory throughout the year (Dr. Wade and Mr. Ryffel: winter, Monday and Thursday 2 to 4; summer, Tuesday and Thursday 2 to 4) and is supplemented by lectures, revision classes, and periodical test examinations. A course of experimental lectures for beginners will commence on Wednesday, October 7th (Dr. Wade, chemical theatre, 2), and a more advanced course for the special examination in January next, on Friday, October 2nd (Dr. Wade, chemical theatre, 10).

Oxford, Cambridge, or Durham students desiring to work at chemistry should communicate with the demonstrators.

The practical knowledge of toxicology required at the degree examinations of the London and other Universities may be obtained at classes held by Mr. Ryffel during the latter part of the winter and summer sessions. W.

PRACTICAL PHARMACY, MATERIA MEDICA, DISPENSING.

These subjects are taught in the practical pharmacy class at the hospital dispensary, by Mr. Finnemore. This course meets the requirements of students preparing for the Conjoint examination in practical pharmacy and the intermediate M.B. Lond. The study of the physical characters, and chemical properties of substances used in medicine, and preparations made from them, and the doses in which they may be given, requires some considerable amount of application and exercise of memory. The instruction given in the class is therefore very practical, and every assistance is given to the student by demonstrations, access to materia medica specimens, and *vivâ voce* examinations, in acquiring a sound knowledge of materia medica. The art of dispensing, the writing of prescriptions, and the method of prescribing drugs, form also part of the instruction given in the practical pharmacy class. During the year there are three courses of three months each, so that the student can enter at the time most convenient to him.

PHARMACY, PHARMACOLOGY AND THERAPEUTICS.

Lectures are given during the summer session in the anatomical theatre, by Sir Cooper Perry. This course is intended to meet the requirements of students preparing for the third Conjoint examination in pharmacology and therapeutics, for the intermediate M.B. and final M.B. Lond., and the third M.B. Cambridge.

MEDICINE.

Medicine lectures are held on Mondays and Fridays at 4 p.m., and Wednesdays at 3 p.m., in the anatomical theatre, throughout the winter session, by Dr. Taylor and Dr. Hale White. The introductory lecture will be given by Dr. Taylor, on Friday, October 2nd, who will then proceed to discuss "Fever, Contagion and Specific Diseases."

A clinical lecture is delivered every Saturday, at 1 p.m., in the physiological theatre, the first of which will be given by Dr. Hale-White, on Saturday, October 3rd. These lectures are held at 1 p.m., so as to enable footballers to attend, and they finish in time for them to catch the 2.23 train to Honor Oak Park.

THE MEDICAL WARDS.

Clinical instruction in medicine is given in the medical wards to the medical ward clerks and other students who choose to be present, by the physicians, who visit their cases from 2 to 5 p.m., and by the medical registrars in the mornings from 10 a.m. to 1 p.m., and by the House Physicians and Clinical Assistants to their clerks. There are two male wards, Addison and Stephen, each containing fifty beds, and two female wards, Mary and Esther, containing forty beds and four cots each. Dr. Taylor and Dr. Hale White divide the beds in Addison and Mary wards between them, and Dr. Pitt and Sir Cooper Perry those in Stephen and Esther wards. On Mondays and Thursdays the wards are visited in the afternoon by all the physicians; on Tuesdays by Dr. Hale White and Sir Cooper Perry; and on Fridays by Dr. Pitt. The medical registrar, corresponding to Dr. Taylor and Dr. Hale White sees cases on Tuesday, Thursday, and Saturday mornings. The medical registrar corresponding to Dr.

Pitt and Sir Cooper Perry, on Monday, Wednesday, and Friday. Thirty-six medical ward clerks are appointed every three months, and are eligible for reappointment at the end of this time for a further period of three months, the extension being given to those who have shown the most care and diligence in the discharge of their duties.

Case-taking.—Reports are made by the medical ward clerks on all the cases admitted to the wards, under supervision of the medical registrars, who instruct the clerks in the mornings in the method of case-taking and the physical examination of the patients. To each physician is appointed a clinical assistant, who with the registrars superintends the writing of the reports and helps the clerks in any special examination of blood, urine, etc., which may be necessary.

The reports are written on special sheets, kept for the purpose in each ward, and the name, age, address, etc., of the patient should be carefully filled in, as well as any previous admissions into the hospital. In the latter case the abstract of the old report should be copied into the new report. Details as to how to find an old report will be found posted in the medical registrars' room. Ward clerks should always make brief abstracts of the case at the end of the report, and in case of death the post-mortem abstract should be copied in, and when the report is finished it should be handed to the clinical assistant, who eventually sends it to the medical registrar. Where possible it is as well to put in the report what the physician said about the case, and especially his diagnosis, but clinical teaching on the disease in general should not be recorded, and great care must be taken to report the physicians accurately.

Classes.—On Thursdays classes are held for all medical ward clerks at 12 o'clock, in the surgical class-room, on the methods of medical diagnosis, and the explanation of physical signs, etc. During the first six weeks of each three months, classes are held in the clinical laboratory for the junior clerks on the practical examination of urines and blood, and the use of the ophthalmoscope, laryngoscope, and other apparatus. During the last six weeks practical classes on ophthalmoscopic work are given by the ophthalmic and medical registrars.

The times of the classes will be found posted in the halls of Stephen and Addison wards.

The Clinical Laboratory (opposite the lift in the medical buildings) is intended for special microscopical examinations of blood, urine, etc. A special bench is reserved for ward clerks in the physiological laboratory, where all chemical tests and analyses in connection with ward work may be carried out.

Medical Instruments. — A laryngoscope, cyrtometer, anæsthesiometer, etc., are kept in Esther ward, and can be had, on application, from the Sister. Instruments for examining blood are provided in Mary, Esther, Addison and Stephen wards.

Tubes for taking cultivations, and pipettes for holding blood for Widal's serum reaction in typhoid fever, can also be had from the Sisters of the wards, but these should not be used except with the help of the clinical assistant, the house-physician, or medical registrar.

It is very important that the clerk should find out the result of the investigations made by the bacteriologist and record it in the report.

A few practical hints.—Never lose an opportunity of examining a patient for yourself, and then find out what you ought to have noticed. It is only by constant practice that you can train your senses to appreciate the signs of disease, and without this skill, mere book knowledge is valueless. Therefore, listen to the normal as well as the abnormal, and get into the way of examining your cases with some method, so that you have an intelligent idea of what you are trying to find out. Although only a few cases are under your immediate care it is not intended that you should limit your observations to these, but you should know well all the cases under your physician, and something about all the interesting ones in the medical wards. To do this, when your own cases have been attended to, you should go round with the registrar, or examine the patients allotted to other clerks, and ask what points of interest there are about each case. Also, when your physician is not going round, attend someone else's clinical instruction, either in the wards or at out-patients Above all, remember that many of the patients think you to be a "doctor," and treat them as patients, and not as pathological specimens. You cannot be too gentle in an examination of a patient, nor too considerate for the feelings of a sick person. Remember, too, that though the post-mortem room should not be mentioned before patients, yet it is there that you will learn a great deal of medicine, and for you to know your business thoroughly you should never miss an opportunity of seeing the organs whose condition you have tried to make out during life.

As regards reading, Taylor's or Osler's Medicine are the best books, and at first you should read up your own cases and then others as you come across them. Hutchinson and Rainey's Clinical Methods, or Gibson and Russell's Outlines of Physical Diagnosis will also help you very much. M. R.

PATHOLOGY.

The large number of courses of instruction in pathology given in the school leads to some uncertainty in the student's mind as to the order and period of the curriculum in which they should be taken. Pathology is one of the few good things of which it is impossible to have too much, and probably the best advice that can be given to a student who has passed his second conjoint or intermediate M.B. is to take the instruction in pathology which is offered to him as early and often as possible. Most of the instruction in pathology is given in the early morning, so that it shall clash as little as possible with work in the wards, and it is rarely advisable to postpone attending a course till the time arrives, which many seem to expect but fortunately seldom reach, when ward duties shall be less exacting than they are at first. A

man who leaves the dissecting-room in April should begin to attend Dr. Pitt's systematic lectures on pathology in the following summer session (Anatomical Theatre, Saturdays at 9), where he will be introduced to the great principles underlying pathological processes, and will learn something of the theories of disease, which will enable him to understand the facts revealed to him in the post-mortem room. He should remember that this course of lectures is not completed in one year, and that if he attends the lectures for three consecutive years he will each time hear different subjects treated of. If it is in the summer session that a student is released from his anatomical studies, he should begin to learn pathology at the winter demonstrations (Dr. Fawcett and Mr. Steward, Monday, Wednesday and Saturday, 9.15, in class-room No. 2). Here he will be introduced to the treasures of the pathological museum. Selected specimens will be brought from the shelves of the museum for his inspection, and the effects of pathological changes upon the various organs of the body will be demonstrated. The subject is roughly divided into medical and surgical pathology, two days a week being devoted to the former and one to the latter. The whole course occupies two years. At the end of each half-hour demonstration on museum preparations, a *vivâ voce* examination is held on typical recent specimens collected from the post-mortem room and operating theatre.

Valuable as is the instruction afforded by these systematic lectures and demonstrations, they must on no account be allowed to take the place of the daily demonstrations of Morbid Anatomy (Dr. Bryant and Dr. Fawcett, 2 p.m.) in the post-mortem room. Here a student gains information on the relative distribution of morbid processes throughout the body, and learns to verify the accuracy of his observations at the bedside. No ward clerk must on any account neglect to follow the fatal cases to the post-mortem room, and throughout a student's career there is probably no more profitable way of spending an afternoon unappropriated to routine duty than in watching post-mortem examinations. It is not always possible to find time to hold the appointment of post-mortem clerk, but whenever it is the appointment should be held. The man who misses the opportunity while he is at the hospital of becoming acquainted with the many difficulties that may be encountered in making a post-mortem is sure to regret it afterwards.

The practical use of the microscope in solely pathological problems should be learnt as early as possible. With this object the course of Microscopical Pathology (Mr. Bellingham Smith and Mr. Eyre, Tuesday and Friday at 9, in the New Histological Laboratory) should be attended in the first winter session after the student gets into the wards. Here he will gain his first instruction in practical Bacteriology, which he will have constant opportunities of making use of in the wards. Here he will also amplify the knowledge he has already acquired, in the course of Normal Histology, of section cutting and staining, and have demonstrated to him the microscopical appearances of tumours and diseased tissues. A man cannot often find time to attend this course more than once, but he should attend it early in his career and work hard to learn enough about technique to enable him to afterwards examine specimens that constantly come in his way while holding senior appointments. Morbid histology and bacteriology are very engrossing studies, and many good men fight shy of them on account of the amount of time they fear they will "waste" over them. But a man of method can generally find a good many spare moments to devote to this work without seriously interfering with his reading, and he who acquires the hobby will find it a useful one to ride when he has accomplished his examinations and is waiting for patients.

It should be noted that a special class to meet the requirements of Cambridge and other university students has been recently started, in which Dr. Beddard goes over the main points of General Pathology.

BACTERIOLOGY.

The compulsory course in Bacteriology forms part of that in microscopical pathology. As in previous years, the first two months will be occupied with this subject. The rudiments of the science are taught; the methods of staining sputum, pus, etc., to demonstrate bacteria; the methods of collecting morbid products for bacteriological investigation; in fact, the technique of the examinations which can be undertaken in the wards.

A course is also held in the Bacteriological Laboratory during the months of November and December, covering practically the same ground, and is largely intended to meet the requirements of qualified men, and students other than Guy's men.

Two optional systematic courses, each of about two months' duration, are held, beginning in January and May respectively, and especially intended for Final M.B. men and candidates for the Diploma in Public Health. The course consists of lectures and demonstrations of morbid secretions and excretions, water air, protozoa, etc.; susceptibility, immunity, etc. The students are instructed in the practical details of media making, culture, staining, etc., and they examine the more common pathogenic and non-pathogenic bacteria.

SURGERY.

Lectures are held three times a week, on Mondays, Wednesdays and Thursdays, at 9.30 a.m., by Mr. Lucas and Mr. Golding-Bird.

Mr. Golding-Bird for the first part will lecture on "General Surgery," commencing on Friday, October 2nd. Clinical lectures will be given on Mondays, at 1.30 in the physiological theatre, by the surgeons. Mr. Lucas will commence on October 5th. After November 10th the day for the clinical lecture will be changed to Wednesday.

Mr. Steward, six weeks before the final Conjoint examinations in January, April and July, will hold "Revision

Classes." Only those desiring to present themselves for examination are expected to attend.

Sir Alfred Fripp will hold a course of "Operative Surgery" for final M.B. and Fellowship men in October, of which further notice will be given. The course for the requirements of the Conjoint Board will be held in January, 1904, and the fee of 10s. 6d. should be paid not later than December 18th. Names of students desirous of attending the M.B. course, should be left at the Medical Office *before* the end of September. Mr. Brailey will lecture during January to March on "Ophthalmic Surgery," on Wednesday, at 4 p.m., in the ophthalmic operating theatre. The lectures must be attended after passing the second Conjoint examination before admission to the final Conjoint.

Mr. Jacobson holds a Clinical Class on Wednesdays at 2 p.m., in the large operating theatre, for the benefit of candidates for the Conjoint and other examinations in surgery. The classes have proved since their commencement a marked success, and should be attended by all students entering on their final examinations in surgery. We are informed, on good authority, that at least one other member of the surgical staff intends to hold similar classes during the winter session.

THE SURGICAL WARDS.

In the surgical wards there is a division of labour, and corresponding to this division, the appointments fall into two classes—clerking and dressing. The student's first introduction to clinical work is as clerk in the surgical wards, and it is not unlikely that he may, on his first entry, be a trifle discouraged. The reasons for this are obvious. Entirely ignorant of surgery and even of the terms in common use, he is at once required to write full accounts of the cases admitted to the wards. He will find, however, that by paying attention to the advice we give him, that his difficulties will be found to be anything but insurmountable.

Being the junior appointment in the hospital, there is a tendency in the minds of some, and a little more than a tendency in the minds of others, to belittle the post. That is unjust, and is the result of ignorance of the real functions of the surgical clerk. What the medical clerk is to the medical side, the surgical clerk is to the surgical side. The post is junior in point of time, but does not necessarily carry with it any stigma of inferiority. Their duties are identical: the preparation of the permanent hospital records of the cases admitted to the wards. What difference there is consists in this: the machinery of the medical side is less complicated than that on the surgical; whereas the whole of the work in the medical wards falls on the clerk, in the surgical wards it has been found advisable to specialise and to separate—for the sake of greater proficiency—the duties of clerking and dressing. This separation has thoroughly been justified by the results, the chief difficulty being the dependency of the clerk on the dresser for many details of importance. Dressers should, therefore, remember that from them the hospital expects such assistance as will render the reports as complete as they can be made. On the clerk, however, rests the responsibility, and the excellence of his reports is a sure indication of smooth working and mutual assistance in the firm to which he belongs.

The most important point for a clerk to remember is that in after years cases and not book work will form his mainstay in practice, and that he cannot too soon get the clinical entity and results of treatment into his memory.

The appointment of an overseer to each firm of clerks in the person of a clinical assistant in the surgical wards is of inestimable value, primarily to the clerks, secondarily to the whole firm. The clinical assistant should be the immediate "ear" of all his clerks, to instruct them of their duties in the wards, also relieving the surgical registrar of many details in the filling in omissions of the reports of his firm.

We do not wish to exalt the clerk unduly, but to insist merely that in his work the same care and attention to detail, the same knowledge of surgery and human nature are as necessary as in other appointments. Let him bear in mind that to him is given by the hospital the task of keeping its records. These are bound and kept, and by his work thus perpetually in evidence a man is judged. Bad reports are a lasting disgrace; good reports a lasting honour. The importance of good careful work by the clerks cannot be over-estimated. In the nature of things it cannot be perfect, but it must be as perfect as he can make it. By his first work in the wards he will be judged and he will find that it is very hard to live down a bad clerkship. At the same time that he bears in mind the difficulties and responsibilities of his post, he should remember that he is a junior, and that any assistance he can lend his seniors should be offered ungrudgingly, and in return for this he will undoubtedly meet with that consolation and help in his work which is so necessary. There is no loss of dignity sustained in carrying screens to patients, or in the thousand and one small opportunities which present themselves of helping the other workers in the wards.

To the dressers we would submit that the performance of dressing is no part of the clerk's duty, and that it is no kindness to him to request him to undertake what he cannot from his position with good grace refuse, and what neverthless he is unfitted to do.

The work of the firm, as a whole, should be the interest of each individual member of it. Pride should be taken not only in its splinting and dressing, but also in its reporting. A good house-surgeon and a good dresser will see that the reports are not below the level of those of other firms, for as they represent the work of the firm the individual members should see that they give a fair and accurate idea of that work. The clerk, aided by the clinical assistant, from this point of view is to be regarded as the mouthpiece of the firm to succeeding generations. The firm should see that he represents it fairly.

It is essential that either the clerk should live within walking-home distance of the hospital, or else get a room for the take-in week. All really good casualty work is done at night, and the periods for seeing the actual Crofting and treatment of fractures is all too short as it is.

The clerk, as soon as he is appointed, should find out from the surgical registrar to whom he is appointed. A few days before taking over the work he should learn from his predecessor what he can about the cases he is to take charge of, so that the work may be continued as nearly as possible without a break. At the present time there is an entire change of clerks every three months, but in the way indicated above, the break in the work may be obviated to some extent. He should learn quickly to take accurate temperatures, and pulse and respiration rates, and test urine, for without any exception the temperature, pulse and respiration rates, and condition of the urine must be included in the notes of every case on admission. The surgical registrar sees every new case with the clerk on the morning after admission, when he expects a history of every case to be ready. This, if vague, is useless. All symptoms should be set down in exact order, with the dates of their appearance. The exactness in detail is of the highest importance, and is a measure of the care with which the clerk has done his work.

He should have a note-book, and should put down in it everything about the case that he can obtain from the surgeon, house-surgeon, clinical assistant, and dresser. This should be copied into the report as soon as possible. We would impress upon each clerk the value of seeing everything done by the dressers or house-surgeons—the operations, putting up fractures, especially when done at night in take-in week, and this should apply to manipulations on every case under the surgeon, and not only to the cases which the individual clerk has to report—as much may be learnt in this way which otherwise can only later be gathered with much greater effort.

A new departure was made two years ago in the practical surgery classes, which are in the hands of the surgical registrar, who gives four courses a year, each beginning on the appointment of the new surgical ward clerks, and especially designed for their instruction in all matters relating to that appointment.

Lists of the duties appertaining to each appointment are supplied to the students, and these are to be carefully followed out. The hospital not only expects this, but insists on it. We have laid stress so far on the appointment of surgical ward clerk, as it is the first post that the student holds, and because he is so often quite unaware of the objects of the appointment.

He will in time become a dresser, and will by that time have learnt the traditions that underlie his office. He should, before accepting office, have acquired most thoroughly the principles of aseptic surgery, and, on no account, ever depart from them subsequently. Let soap and water be his sheet anchor.

The surgical wards are visited every day by the surgeons and assistant surgeons at 1.45. Notice of operations, which usually take place on Mondays, Tuesdays, Thursdays and Saturdays, except for emergencies, is posted overnight in the colonnade by the House-Surgeon for the week. The surgeons are assisted at the operations by the dressers, and no others should stand about the well of the theatre, the only exception being the particular ward clerk to the case.

Although we believe there is no rule which prevents freshmen attending operations and clinical demonstrations, we would point out that such a course of action is useless to them, and is not encouraged by the authorities.

Finally, we should like to repeat that although specialization has provided a clerk responsible for the drawing up of the hospital records, yet as this report is an account of the work performed by the firm as a whole, it touches the honour of every one in it that the report should be an accurate statement of the work done. The firm should be considered the entity, each separate member of which fulfils his own function, each at the same time being dependent on the others for the smooth, even working of the whole. S. R.

DAYS AND HOURS OF ATTENDANCE ON HOSPITAL PRACTICE.

Accidents and urgent cases of all kinds are admitted by the St. Thomas's Street entrance at any time of the day or night.

THE WARDS.

Medical Wards.—Dr. Taylor (2), Mondays, Thursdays and Fridays. Dr. Hale White (2), Mondays, Tuesdays, Thursdays and Fridays. Dr. Pitt (2), Mondays, Tuesdays, Thursdays and Fridays. Sir Cooper Perry (2), Mondays, Thursdays and Fridays.

Surgical Wards.—Mr. Lucas (2), Mondays, Tuesdays, Thursdays and Fridays at (3.30). Mr. Golding-Bird and Mr. Symonds, Mondays, Tuesdays, Thursdays and Fridays (1.30). Mr. Jacobson, Mondays, Tuesdays, Wednesdays, Thursdays and Fridays (1.30). Operations daily (1.30).

Obstetric Ward.—Dr. Horrocks (2), Tuesdays and Fridays. Mr. Targett (2), Mondays, Wednesdays and Thursdays.

Ophthalmic.—Mr. Higgens (2), Tuesdays and Fridays. Mr. Brailey (2), Thursdays. Operations (2), Tuesdays, Thursdays and Fridays.

THE OUT-PATIENT DEPARTMENT.

The days and hours of attendance in the Out-Patient Department of the hospital are as follows :—

Medical Cases.—Dr. Shaw (1), Fridays. Dr. Bryant (1), Mondays. Dr. Fawcett (1), Thursdays. Dr. Beddard (1), Wednesdays.

Surgical Cases.—Mr. Lane (1), Mondays. Mr. Dunn (1), Wednesdays. Sir Alfred Fripp (1), Thursdays. Mr. Steward (1) Saturdays.

Obstetric.—Mr. Bellingham-Smith (1), Thursdays and Saturdays.

Ophthalmic.—Mr. Higgens (1.30), Mondays. Mr. Brailey (1.30), Tuesdays and Fridays.
Dental.—The Dental Staff (9) every week-day.
Aural.—Mr. Fagge (1), Tuesdays,
Skin.—Sir Cooper Perry (1), Tuesdays.
Throat.—Mr. Steward (1), Fridays.
Electricity.—Dr. Bryant (12 and 3), Wednesdays.

DENTAL SCHOOL.

The dental student is supplied at the Medical Office with the Prospectus, Standing Orders, Notes on Probationary Work, List of Instruments, Calendar, and Clubs' Union Book.

If these pamphlets are carefully perused, he will become well acquainted with the general arrangements of the school, and the scope of the work upon which he will be engaged during his studentship.

It will first be necessary for him to purchase his nstruments at one of the dental depôts, and to satisfy himself that he has been supplied with all of those described in the hospital list.

Probationary work upon the phantom head will occupy the freshman's time for about two months. This operative course is conducted by the staff demonstrators, and is very comprehensive. It includes most of the conservative operations that the student will subsequently perform on patients, namely, gold and other fillings, crowns, inlays, and the treatment of devitalized and septic teeth. If the manipulations upon the dummy are done in a thoroughly sound manner, a capital groundwork of operative dentistry will be acquired. It may be mentioned in passing that too much stress can scarcely be laid upon the necessity of becoming an expert operator, for the public are not slow to appreciate the highest manipulative skill.

The regulations of the Royal College of Surgeons of England require that dental students, who registered on and after January 1st, 1897, shall pass two professional examinations for the dental license. At the first professional examination certificates must be produced *inter alia*, of having been engaged in the practice of dental mechanics under a registered dental surgeon during a period of three years, and of having manufactured and adjusted six dentures and six crowns.

Inasmuch as it is recommended at Guy's that this examination be passed during the month of May, it follows that the work of the first winter session must be largely devoted to demonstrations, dental mechanics, and lectures.

If a student needs help or advice in his work he should consult the Dean, or a member of the Staff, any of whom will gladly do what he can for the best interests of the student. M.

Papers by Guy's Men.

Classification Cards for use in Bacteriology. By Kenneth Goadby, M.R.C.S. Eng., L.R.C.P.—*British Medical Journal*, 12th September.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The London University: A Forecast.

DEAR SIR,—Perhaps the enclosed may clear the issue. "The London University is to be a large teaching and resident University where the diligent may find their examinations but proper tests, their studies unrestricted, and their degrees both economical and attainable in a short period. To this end the entry will be encouraged until the entry for the M.B. includes at least all those who now enter for the Conjoint. Preliminary studies in Arts, Science and Anatomy are to be carried on in centres under recognised teachers, who will also examine, controlled by the wholesome influence of an external and independent examiner. By these means it is thought that a University degree will be brought within the reach of all properly studious men. The course is to be kept to five years inclusive, and the studious, not the gifted, are to complete their studies in five years. No honours or scholarships are to mark invidious superiority, and all cramming to replace diligence, and all external tuition and study whatsoever, is to be abolished in favour of the professional lecture, the laboratory class, and the wise and discerning examiner. In time, corporate life with residential restriction is to spring up, and the University is to be sociably and collectively an entity. In fact, the University is to resemble the Scotch plan as nearly as may be."

FIDUS ACHATES.

The Cases for Diagnosis in the last "Gazette."

DEAR SIR,—As one who is losing touch with the local politics and social life of the hospital, I must thank you for your efforts to keep the GAZETTE interesting and instructive for a past generation of students by the inclusion of much clinical material. Personally, I feel a confidence in what I read in the GAZETTE which I do not enjoy when searching the usual medical journals for points of interest. It is because you at the hospital can carefully watch and note your cases during life, and complete the study after death, that the "cases" you report are so much more instructive than those met in practice, and

because any case of rarity is discussed and criticised before publication your clinical reports are of more value than nine-tenths of those one reads, and rejects as "not proven."

In the first of the "Cases for Diagnosis" in the last GAZETTE, you do not mention whether the patient was fat or thin. Cases of acute pancreatitis occur, as far as I know, only in the stout or fat, and if a similar one to that reported came before me in a thin person I should definitely exclude the diagnosis of pancreatitis. If I am wrong in this, I should be greatly obliged if some one would kindly let me know in the next number of the GAZETTE.

Your second case seems to agree very well to the symptoms of Stokes-Adams' disease. The slow pulse, apoplectiform seizure with Cheyne-Stokes' breathing, the sudden death in bed, and the aortic atheroma are typical of a certain type of this disease, so ably and fully described by Professor Osler in the *Lancet* for August 22nd of this year. The condition of the meninges described after death certainly does not explain the symtoms or mode of dying, so might possibly be a coincidence.

I feel very chary of offering a diagnosis of a case I have never seen, but in the hopes that this letter may draw some further remarks and explanations from an authority about this very interesting case, I send it to you.—I am, yours truly, A. J. C.

In the last issue there was a misprint, *anæmia* should have been *uræmia*. The second case was therefore uræmia or syphilitic meningitis.—ED.

Influenza accompanied by a rash.

SIR,—Can any of your readers give me definite information as to cases of influenza accompanied by a rash? I attended such a case in a servant three miles away last week, which could hardly have been scarlet fever, as the pulse was only 64 and the temperature was normal when I was called in. There was a sore throat, the tongue was unlike that of scarlet fever, and the rash, which only occurred on the face, reminded one of faint and rather brownish measles or German measles, but avoided the vicinity of the mouth and was rather itchy. Five days later her sister, who slept with her, developed a typical attack of influenza, without any scre throat or rash.

In another case, about a fortnight after the acute stage, which was severe, I found both hands peeling, one extensively. This lady tells me she has always had a sensitive skin, and noticed some small spots about the fingers when she was beginning to recover from the more acute stage of the illness. There was no rash about the face beyond a general flushing of the cheeks when the temperature was at its highest and stimulants were being given every few hours. Do these cases at all fit in with those which have been designated "Fourth Disease?" I shall be glad of any criticisms or suggestions,—Faithfully yours,

Whitby, Yorkshire. A. J. SHARP.

Guy's Hospital Clubs' Union.

THE FORMATION OF THE CLUBS' UNION, by the amalgamation of the various constituent institutions, took place in the summer of 1891. The objects of the amalgamation are to further the interests of the clubs and societies existing at the hospital by their mutual support, and to simplify the collection of subscriptions. By the payment of an annual subscription (see Clubs' Union Blue Book, p. 17) to the Clubs' Union, any student of the hospital can obtain the privilege of membership of the constituent institutions.

THE GROUND OF THE CLUBS' UNION, which is under the control of the council, is situated close to Honor Oak Park Station, on the London, Brighton and South Coast Railway, and to the Crofton Park Station on the South Eastern and Chatham Railway. It is nine acres in extent, and is the headquarters of the Guy's Football, Cricket, Athletic and Lawn Tennis Clubs. Under such restrictions as are found necessary by the committees of the several clubs, and are approved by the council of the Clubs' Union, every member of the Union has opportunities of practising and taking part in matches, and in the various sports and games. There is a large pavilion upon the ground, with dressing and lavatory accommodation. Refreshments can be obtained by members of the Union according to the tariff of the Students' Club.

THE HOSPITAL "BLUE."—The "Blues" Committee, consisting of two representatives from each associated club, award "Blues" and "Half-Blues" to members of the following teams:—Rugby Football, Association Football, Cricket, Athletic, Lawn Tennis, and Water Polo, after considering the list of men suggested by the various Clubs' Committees through their delegates. Blues are awarded half-yearly, at the end of each session, so that the Rugby Football team be represented by fifteen Blues, the Association Football by eleven Blues, Cricket by eleven Blues. Blues and Half-Blues are awarded for Athletics, dependent on the recommendation of the Athletic Committee according to the performances at the Inter-Hospital Sports, while there are allotted to the Lawn Tennis three Blues and three Half-Blues, to the Water Polo seven Half-Blues.

CONSTITUENT INSTITUTIONS.

THE FOOTBALL CLUBS.—President, Frederick Taylor, M.D. Rugby—Captain, E. Morgan: Hon. Sec., M. G. Louisson; Captain Second XV., W. H. Burney; Captain Third XV., H. W. Marshall; Captain Fourth XV., T. Norman: and a committee of five, one representing each year. Association—Captain, H. Barber; Hon. Sec., E. L. Norton; Captain Second XI., P. A. Peall; Captain Third XI., H. A. Watney; and a committee of five, one representing each year.

The Rugby Football Club has now been in existence for over fifty years, the season 1903–4 being the 60th. Very little is known about its early history. Among the many brilliant players who at one time or another have appeared for Guy's may be mentioned the following International footballers:—A. W. Pearson, W. W. Pinching, A. H. Jackson, L. Stokes (captain 1877–8), A. S. Taylor, W. G. Mitchell, A. Allport, H. W. Dudgeon (England); H. M. Jordan (Wales); R. Evans (Scotland); F. O. Stoker (Ireland); and E. Morgan (Wales).

In 1874 the Inter-Hospital Challenge Cup was instituted, which Guy's was fortunate enough to secure for the first time. Since its institution, St. Thomas's has held the Cup ten times; Guy's eight times; St. George's three times; London and St. Bartholomew's twice each; and Middlesex and St. Mary's once each.

In 1891, Guy's, Middlesex and St. Thomas's were left in, the ties not being played out.

Last year, after most brilliant displays in the Inter-Hospital matches, we retained possession of the cup; and from the present aspect of affairs there is no reason why we should not keep our prestige in this coming season, if only men will evince the same keenness which they showed during the past year. We have four fixture lists arranged this season, and we propose to hold trial games at the beginning of the season, the first being fixed for October 3rd. A complete list of the fixtures will be given in the next issue of the GAZETTE.

For the benefit of freshmen in particular, we may state that lists will be put up in the smoking-room and elsewhere, on which intending players should place their names as early as possible.

The officers of the club will be at all times very glad to give any information in their power.

The Association Football Club began its career in 1882, and has been carried on with much success since that time. In 1886 the Inter-Hospital Challenge Cup came into existence, and was won by Guy's for the first four years after its institution; during these years the Hospital twice won the Surrey County Challenge Cup. In 1894 and 1897 we again held the Inter-Hospital Cup, making in all six times. Reviewing last season, it may be said to have been very successful, winding up a most satisfactory season by bringing back the Cup. In the Surrey Cup, also, we did much better, remaining in till the fourth round. Most of last year's team are available for this year, and a good season is anticipated. The second eleven had an eminently successful season and played regularly throughout, doing well in the Surrey Junior Ties, and winning the Inter-Hospital Junior Cup for the third time in the course of its brief existence. The third eleven played frequently too. On October 3rd and 7th trial games at Honor Oak Park have been arranged, more especially for the benefit of freshmen, and it is hoped that no freshman interested in "soccer" will hesitate for any reason to avail himself of this opportunity of proving his worth on the field, for it is largely on the result of these games that his inclusion in the teams later depends. Notices of the trial games will be duly posted in the Smoking Room of the College. In the next issue of the GAZETTE a complete list of the season's fixtures will be given.

THE CRICKET CLUB.—President: W. A. Brailey, Esq., M.D. Captain: H. M. Langdale. Vice-Captain: H. D. Wyatt. Hon. Secretary: F. Morres. Captain 2nd XI.: A. M. Tolhurst. Captain 3rd XI.: G. N. Harvey, and a committee of five.

Guy's have the best cricket ground of any London hospital and generally turn out a good cricket team.

Since the institution of the Hospital Cup in 1882, we have won it on thirteen occasions. The Cup was won this season, Guy's beating Thomas's, Bart.'s, in the second round of the Cup tie, and Mary's in the final.

We should like to add that our prospects for the immediate future are fairly hopeful, and that though the Cup-ties lend themselves better to records, we do not wish to give them undue prominence, as perhaps many of our ordinary time-honoured fixtures are the more enjoyable matches.

THE ATHLETIC CLUB.—President: R. Clement Lucas Esq., B.S., F.R.C.S., Hon. Secretaries and Treasurers: J. E. Hodson and P. S. Litchfield; and a committee of eleven. The annual meeting of the Athletic Club is held in June at the Clubs' Union Ground.

THE LAWN TENNIS CLUB.—President: W. Arbuthnot Lane, M.S., F.R.C.S. Captain: T. C. Lucas. Hon. Secretary and Treasurer: F. W M. Palmer; and a committee of eight. The club has been in existence some eleven years. There are sixteen very good grass courts at Honor Oak, which are open for play from the end of April to the end of September. The club holds, at the beginning of the season, several trial games, which serve to bring before the notice of the committee all promising new players, while one or two matches are played weekly against various London clubs. The Inter-Hospital Challenge Cup was instituted in Jubilee year; it was held by St. George's until 1890; Guy's held it in 1891-1892; St. Thomas's, 1893–1896; St. Bartholomew's, 1897; London, 1898; St. Bartholomew's, 1899 and 1900. In 1901 it was won by St. Thomas's, by London in 1902, and by St. George's in 1903. A cup was also presented in 1899 by the late Dr. Washbourn, for a competition for second teams, which has been won this year by St. Thomas's.

THE RIFLE ASSOCIATION.—President: L. A. Dunn, M.S., F.R.C.S. Vice-Presidents: G. Newton Pitt, M.D., A. P. Beddard, M.D., E. I. Spriggs, M.D. Captain: O. B. Travers. Hon. Secretary and Treasurer: R. Felton; and a committee of five.

The Association arranges matches with the sister hospitals of London and with public school cadet corps, and also enters a team to compete for the United Hospitals Challenge Cup at Bisley during the "week." Both civilians and volunteers are now allowed to compete in the United Hospital Competitions and in the

Bisley Cup; but there are numerous advantages attendant on a membership of a Volunteer Corps, and the honorary secretary of the Association will readily give any information required with regard to suitable corps.

The Annual Prize Meeting and the Newton Pitt Challenge Cup Competition are held in July, before the close of the session. Due notice of these and all other events will be posted on the notice board in the Colonnade.

It is earnestly requested that each and every man interested in shooting will communicate early with the Secretary, so that the Committee may have some idea of the number of men for whom they have to arrange next season's programme.

The Annual General Meeting will be held early in October (notice of exact date will be posted conspicuously) and it is hoped there will be a good attendance.

GUY'S HOSPITAL SWIMMING CLUB.—President: Sir Alfred Fripp, M.S. Vice-Presidents: L. A. Dunn, Esq., M.S., J. Fawcett, Esq., M.D. Captain: A. L. Moon. Vice-Captain: L. V. Ransford. Hon. Sec. and Treas.: R. B. Dawson.

THE PUPILS' PHYSICAL SOCIETY.—Hon. President: Sir Samuel Wilks, Bart., M.D., LL.D., F.R.S. Hon. Secretaries: E. I. Spriggs, M.D., and R. P. Rowlands, B.S.

This flourishing society was founded in 1830, on the plan of the old Physical Society, which existed during the latter part of the eighteenth century at Guy's Hospital.

At the Pupils' Physical Society, which meets on Wednesday evenings each fortnight, a paper on some subject, not necessarily of medical interest, may be read by any member, to be followed by a discussion.

"Clinical and Pathological Evenings" are devoted to the exhibition and discussion of interesting cases or specimens which may be shown by any member.

Members are reminded that in connection with the Society the following prizes are offered for competition:—The Treasurer's Prize of £5 is given annually, and the subject of the Essay for the ensuing session will be announced later. The Society offers a prize of £10 for the best paper read during the session; a prize of £5 to the member who distinguishes himself most in the discussions; and a prize of £5 to the member who exhibits the best specimens of scientific interest during the session (see Clubs' Union Blue Book, page 46).

THE DENTAL SOCIETY.—President: W. A. Maggs, Esq., M.R.C.S., L.R.C.P., L.D.S. Hon. Secretary and Treasurer: F. W. Parfitt. Committee: R. Glendinning, A. E. D. Prideaux, A. D. Crofts, A. Alan Forty, J. W. Mawer.

The Society was founded in the early part of 1894. Its ninth session commenced in October last, and was eminently successful in every way; good papers were read and much interest was taken in the meetings by the members.

Meetings are held every month during the winter session. They are held in the Dental Lecture-room on the second Friday in each month, at 4 p.m. Papers on subjects of dental interest are read, after which a discussion takes place; clinical cases are also shown at each meeting; and one evening during the session is specially set apart as a clinical evening.

THE DEBATING SOCIETY.—President: G. H. Savage, Esq., M.D., F.R.C.P. Vice-Presidents: J. Fawcett, Esq., M.D, A. W. Ormond, Esq., F.R.C.S., and E. I. Spriggs, Esq., M.D. Hon. Secretary: R. Edridge and a Committee of five students.

The Debating Society is entering on its twelfth year of existence, and its tenth as a constituent of the Clubs' Union.

Five meetings are usually held in rotation with those of the Physical Society and the Smoking Concerts. Any subject except theology may be debated. Private business is allowed. A "Ladies' Night" is held at the end of the Session, at which members bring their friends, who are eligible to speak.

THE GUY'S HOSPITAL GAZETTE is published on alternate Saturdays, from the library of the hospital, where copies may be obtained by all members of the Clubs' Union and by immediate subscribers.

Established in 1872, the GAZETTE was the first Journal of its kind ever published in this country. It ran an uninterrupted course until November, 1879, and was then suppressed by the hospital authorities rather from excess of zeal than from lack of material. The present "new series" was inaugurated in 1887, and since that time it has continued to flourish without a break. The original GAZETTE was a two-leaf publication, and only had a small circulation in the hospital itself. Its circulation now practically includes all Guy's men throughout the world, as well as the Nursing Staff, past and present.

The management of the GAZETTE is vested in a committee constituted as follows. Three members of the Hospital or School Staff, *appointed yearly* by a School Meeting. Two students, appointed yearly by the Clubs' Union Council. The President of the Residents for the time being. An Editor appointed by the Committee. A Manager appointed by the Committee, and other students not less than four in number and not more than six co-opted by the Committee.

The columns of the GAZETTE are open to contributions and correspondence from all sources, the writer's name being requisite as a guarantee of good faith, if not for publication. All contributions must be deposited in the editor's box in the colonnade, or addressed to the editor by post not later than Wednesday in each week of issue.

THE REPORTS.—Edited by J. H. Bryant, M.D., and F. J. Steward, M.S.

The first volume of the Guy's Hospital Reports appeared in 1836. The Reports are published periodically, and contain contributions upon professional and scientific subjects from the staff of the Hospital and Medical School.

THE STUDENTS' CLUB.—Committee till 1904 (March). President: P. H. Pye-Smith, M.D., F.R.S. Treasurer: W. Hale White, M.D. Hon. Secretary: A. W. Ormond, F.R.C.S. Hon. Assistant Secretary: R. P. Rowlands, and a committee of eight.

The above-named manage the affairs of the Club, a full account of which will be found in the Clubs' Union Blue Book, p. 53.

GYMNASIUM.

The Pavy Gymnasium, which was built and furnished by the liberality of Dr. Pavy, is open daily for practice, and during the winter session a boxing instructor attends one day a week, and also a gymnastic and fencing instructor. At the end of the session a competition for prizes is held, and a display of gymnastics and boxing and fencing is given on the "Ladies' Night."

Reviews.

The price of books submitted for review should in every case be stated.

The insanitary condition of Standerton, Transvaal.—During the autumn and winter of 1899–1900, the letters of Dr. Fremantle in the Guy's GAZETTE first exposed the breakdown of the Medical Department on active service, a breakdown that all had predicted who knew its state.

The above treatise by Mr. Coplans carries in detail an analysis of the causes of dysentery and enteric in one of the large standing military and concentration camps, and it is very melancholy reading.

The details of its disregard of hygiene, and of the arrival of fresh troops compelled to accept the same conditions is unpleasant reading, and all will agree in the conclusion that "one lesson is to be learned from all this, the paramount necessity of a central sanitary authority for all areas where humanity does congregate; the need of the institution of a system of medical health inspectors for all portions of a civilised country—both during peace and war — acting under a central supreme sanitary authority." It is to be clearly understood that the R.A.M.C. and the Military Administration were in no way responsible for the condition they found, and in the absence of a sanitary authority were powerless to improve it.

The editorial comment of Professor Simpson is also pointed:—

"We have heard a great deal of the inevitable sickness which must occur in armies. Dust storms and other climatic factors are freely quoted by apologists as predominating agents in the production of disease; but it is significant that in any enquiry into the actual condition of things, we are forcibly brought back to a neglect of the ordinary canons of sanitary law, and that the only inevitableness likely to be discovered is the absence of sanitary administration."

These are hard words, but elsewhere the actual arrangements existing merited them, but we are confident that the R.A.M.C. will under its present greatly improved management, in a few years be a model department of state, and that it will be converted from being a reproach into a really first-class and efficient service; in fact, as citizens we wish we could see the same certain prospect of reform and improvement in the fighting part, where apparently the same lack of effective control is still existing.

Elementary Bacteriology.—By M. L. Dhingra, M.D. 141 pages, 26 illustrations. (Messrs. Longmans, Green & Co.) 3s. net.

Bacteriology is in general an abstruse and dry subject, but Dr. Dhingra has succeeded in making the above book quite an interesting study. He has aimed successfully at pointing out principles and suggesting problems rather than marshalling facts.

There is little that is absolutely new but it is a very useful summary for anyone who wishes to learn about microbes some simple facts, interesting details and speculations.

It is not absolutely up to date, the absence of any reference to the pneumococcal form of peritonitis, and of all mention of Ainley Walker's researches in Rheumatism being perhaps the most notable. We can recommend it to practitioners who have not a book on bacteriology.

Protozoa and Disease.—By J. Jackson Clarke. (Baillière, Tindall & Cox. 1903.) 197 pages, 91 illustrations. 7s. 6d., net.

The study of protozoa will be a necessity in the future, and although at present, as the author truly remarks, "one disease malaria is known to be caused by protozoa," it is probable that soon discoveries will elucidate many diseases that would be easily explained on a similar protozoan causation.

The book is an admirable deep compilation of the salient facts that are definitely ascertained with regard to protozoa as parasites and pathogenic organisation.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane* :—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

G. M., HERTFORD.—This is a spindle-celled sarcoma, the elements of which are arranged in interlacing bundles. Much of the tissue is ulcerated and necrotic.

T., NEWINGTON CAUSEWAY.—Reaction alkaline, sp. gr. 1012; albumen small amount, blood *vide infra*, sugar absent. *Microscopical examination of the centrifugalised deposit*: The deposit contains numerous bacteria associated with the decomposition of the urine, and a few triple phosphate crystals. In addition there are some scattered red blood discs and a slight excess of leucocytes. Tube casts cannot be found.

NOTE.—The decomposed state of the specimen renders it somewhat unfavourable for microscopical examination.

J. R. A., CHADWELL HEATH.—This sputum contained a fair number of tubercle bacilli.

H. L., MANCHESTER.—This specimen has the characteristic structure of a tuberculous ulcer of the tongue. There is a small punctured wound or ulcer in the centre, and the subjacent tissues and muscle are thickly infiltrated with miliary tubercles. The giant-cell systems are very large and distinct. Probably infection has occurred through the puncture of a jagged tooth. Is there any evidence of phthisis or laryngitis ?

S., HUTTON RUDBY.—This sputum contained some pus but no tubercle bacilli were found.

PATHOLOGIST.

Papers by Guy's Men.

A Clinical Lecture on a case of Abscess of the Temporo-sphenoidal Lobe presenting symptoms of "Amnesic Aphasia"; Operation; Recovery. By R. Lawford Knaggs, M.A , M.C. Cantab, F.R.C.S. Eng.—*Lancet*, 19th September.

On the Detection of Lead in Urine and Post-mortem Specimens. By J. W. Mellor, D.Sc., and Frank Shufflebotham, M.A., M.B., B.C. Cantab.—*Ibid*, 12th September.

Calendar of Coming Events.

September, 1903.

Sat. 26.—Messrs. Golding-Bird and Dunn's take-in; Drs., A. S. Littlejohns and P. E. Minett; Cl., A. R. Brailey.

October.

Thur. 1.—Winter Session begins.
November Appointment List opened.
Mr. Jacobson and Sir Alfred Fripp's take-in; Drs., A. Leeming and R. Felton; Cl., C. H. Reinhold.

Sat. 3.—1.0 p.m., Clinical lecture by Dr. Hale White.
G.H.R.F.C., I., trial game.
G.H.A.F.C., I., trial game.

Mon. 5.—1.15 p.m., Clinical lecture by Mr. Clement Lucas.

Tues. 6.—First part Camb. D.P.H. Exam. begins.
First Conjoint Exam. begins.
Preliminary Science (L.D.S.) Exam.
Test Exam. for L.D.S. Eng.
Test Exam. for 1st. Professional Exam. for L.D.S. Eng.

Wed. 7.—G.H.A.F.C., I., trial game.

Thur. 8.—November Appointment List closed.
Second Conjoint Exam. begins.
Messrs. Symonds and Steward's take-in; Drs., L. J. J. Orpen and H. D. Wyatt; Cl., G. Goldie.

Fri. 9.—School Exam. in Elementary Anatomy.

Sat. 10.—1.0 p.m., Clinical lecture by Dr. Hale White.
G.H.A.F.C., I., v. Surbiton Hill, home.

Birth.

HOLMAN.—On September 21st, at Galestone, Eton Avenue, Hampstead, N.W., the wife of Frank Kay Holman, M.R.C.S., L.R.C.P., of a daughter.

Marriage.

CHURCHWARD—MUNDY.—On September 5th, at Christ Church, St. Leonards-on-Sea, Albert Churchward, M.D., M.R.C.P., M.R.C.S., to Janie Elizabeth Marie, daughter of Henry Mundy.

Death.

MAILLARD.—On September 10th, at Crete, Richmond Wood Road, Staff-Surgeon W. J. Maillard. V.C., R.N. (retired), aged 40 years.

ED.—J. M. B.

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Notice.

All Communications, Articles, Letters, Notices, and Books or Review should be forwarded, accompanied by the name of the sender, to the Editor, Guy's Hospital Gazette, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the Gazette *bound should leave them with the Librarian.*

The annual Subscription to the Gazette *is* 6s. 6d.; *post free,* 7s. 6d *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. Wells, Secretary's Office, Guy's Hospital.

The charge for binding in blue, with the Arms of the Hospital in gold, will be One Shilling and Sixpence.

Calendar of Coming Events.

October, 1903.

Sat. 10.—G.H.P.P.S., Opening Meeting. "Pitfalls." J. F. Goodhart, M.D., LL.D. Sir Samuel Wilks in the Chair.
1.0 p.m., Clinical lecture by Dr. Hale White.
Messrs. Symonds and Steward's take-in; Drs., L. J. J. Orpen and H. D. Wyatt; Cl., W. F. Box.
G.H.R.F.C., I., v. Lennox, home.
II., v. Lennox II., away.
G.H.A.F.C., I., v. Surbiton Hill, home.

Mon. 12.—1.15 p.m., Clinical lecture by Dr. Horrocks.

Tues. 13.—Second Part Camb. D.P.H. Exam. begins.
1.15 p.m., Clinical lecture by Mr. Lucas.
Exam. in Dental Histology.

Wed. 14.—G.H.R.F.C., III., v. King's College Eng. II., away.

Thur. 15.—Messrs. Lucas and Lane's take-in; Drs., R. Edridge and J. E. Spiller; Cl., G. Goldie.

Fri. 16.—Meeting of the Dental Society at 4.15. p.m.

Sat. 17.—1 p.m., Clinical lecture by Dr. Hale White.
G.H.R.F.C., I., v. Catford Bridge, away.
II., v. Catford Bridge II., home.
III., v. Park House B, away.
G.H.A.F.C., I., v. Normanhurst Druids, home.
II., v. Normanhurst Druids, away.

Mon. 19.—1.15 p.m., Clinical lecture by Mr. Higgens.

Tues. 20.—1.15 p.m., Clinical lecture by Mr. Lucas.

Wed. 21.—G.H.R.F.C., I., v. Cambridge University, away.
II., v. Borough Road College, home.

Thur. 22.—Messrs. Golding-Bird and Dunn's take-in; Drs. J. Cook and A. M. Roome; Cl., P. A. Peall.
G.H.C.U., address by Rev. W. R. Mowll, M.A.

Sat. 24.—1 p.m., Clinical lecture by Dr. Hale White.
G.H.R.F.C., I., v. Rosslyn Park, home.
II., v. Surbiton A, away.
III., v. Old Alleynians III., away.
G.H.A.F.C., I., Clapham Rovers, home.
II., Clapham Rovers, away.
G.H.P.P.S., Clinical Meeting. President, C. H. Robertson.

Guy's Hospital Gazette,

OCTOBER 10, 1903.

Some Practical Points in the Pathology and Treatment of Tuberculosis of the Testicle.

CLINICAL LECTURE BY MR. W. H. A. JACOBSON.

Gentlemen,—I have selected this subject for two of my lectures for the following reasons. (1) Its importance. We shall see that this disease occurs at the time of chief sexual activity, we will say from twenty to forty; we shall see also that it has, if neglected, a great tendency to spread to adjacent parts, and the greatest possible misery and danger lie before a patient if tuberculosis of the testis is allowed to run on, as it very often is, to tuberculosis of the genito-urinary system, particularly the bladder and the kidney. Another point in its importance with which I shall deal is the marked tendency of the disease to attack both sides at a varying interval of time. Your text-books give very insufficient attention to this point. These three specimens which I bring before you will serve to fix it on your mind.

This one shows the left testis and epididymis, both the seat of tuberculosis, removed from a medical man in practice in London, four years having elapsed since a similar operation was required on the left side. These two specimens show the testes and epididymes, even more extensively involved, removed from a clergyman at one operation, two months only having elapsed between the dates at which first the right and then the left sides were involved. (2) Secondly, this disease, like many other tubercular ones, always seems to me to be one which if not an opprobrium to us, is one in which we fail to do ourselves credit. Thus, like many tuberculoses, it begins usually insidiously and painlessly. The patient often fails to notice it early, or if he do so, keeps it to himself, owing to the nature of the organ attacked. But when due allowance is made for the above explanation of, and excuses for our not getting this disease in its earliest and most favourable stage, I recall many cases, especially when I was attending out-patients, in an early stage, in which I let these cases drift on, without anything active being done, perhaps ordering a suspensory bandage and some ointment of belladonna and mercury oleate, my only excuse being that till recently the only operation of any real value in these cases has been castration, and that one shrank from advising such a step in the early stage in such an organ in a patient in the full vigour of sexual power. And this leads me to the last reason for my bringing this subject before you. (3) Of late years German and French surgeons have been trying another operation, that of epididymectomy; of my experience of this I shall speak later. In 1900 this subject of tubercular disease of the testis was chosen for discussion at the French Surgical Congress, and in 1901 by the corresponding society in Germany, and it is high time that in this country also this most important subject should be re-considered and the value of any new treatment duly tested and justly estimated.

As you will see in the abstracts which I have handed round, my remarks fall under four heads: 1. Some practical points in the pathology and causation of tuberculosis of the testicle. 2. The different modes in which these organs may become affected. 3. The various directions in which this form of tuberculosis may spread. 4. Here I shall discuss the treatment.

1. *Some practical points in the pathology and causation of tuberculosis of the testicle.*—Now I will say at once that the above term, although legitimate owing to the importance of the organ, is not quite correct. In the great majority of cases the primary initial focus of the disease begins and remains for a varying time in the epididymis, not the testicle; and further, in the great majority of cases it is the unifocal, single centre of tubercle in the genito-urinary system, though this single focus proves too often to be a centre of radiation of the disesse. While the above statements have been and are still disputed, I believe them to be based on fact, and it is of course on their accuracy and on our getting this disease in its early stage, while it is still limited to the epididymis, that the replacement of castration by epididymectomy depends. When the epididymis is attacked by tubercle, the stages of the disease are, in the great majority of cases, the same as elsewhere. The disease runs at first a slow insidious course, through (1) the stage of arrival of the bacilli, (2) that of their adhesion. This is a most important one. As in the case of the lung, where we all know it is not enough for tubercle bacilli to arrive by inhalation, so here also they must *adhere*, and I shall try and show you, in some detail, what conditions there are in the epididymis and in the clinical history of these cases which favour *adhesion* of the bacilli. (3) Proliferation or growth, (4) Caseation, (5) Suppuration, (6) Sinus, (7) Healing. This is usually imperfect, and in the tuberculosis that we are considering may be likened to an armed truce, the activity of the bacilli being easily lighted up again. We will now turn to the causes of tuberculosis of the epididymis, and try and explain how one organ is attacked, and often both, as I have said, and usually at the most important stage of its functional activity. I believe that in every chronic tuberculosis there is some predisposing cause, either anatomical or physiological, in the organ attacked. I will just give two or three instances. To take the lungs. Here we have anatomical predisposing points in the delicate

terminal infundibula where the air tends to stagnate slightly and for a time, in order that the needful changes between it and the blood may take place. Here also are the minute patches of adenoid tissue, interalveolar and interlobular, in which different micro-organisms may be filtered off and destroyed before they are carried up by the ciliated epithelium to the higher air passages. The physiological predisposing point is, of course, the inhalation of air and dust, these favouring the adhesion of bacilli. Take the lymphatic glands, cervical, mediastinal, mesenteric; the anatomical and physiological points which here predispose so markedly to tuberculosis lie in the fact that their structure and function are identical, only on a large scale, with the minute patches of adenoid tissue in the lungs already mentioned. In every case we have filters and graveyards for bacilli, but be it remembered that, in every case, the completeness of the filtration and destruction depend on the health and vigour of the cells. With one more instance I have done. Take the epiphysial lines. In their complicated, delicate, many and varied celled-structure, their great vascularity with hosts of thin-walled, and often incomplete loops we have physiological and anatomical points which explain how easily in these lines the equilibrium between health and disease may be disturbed, and how small may be the resistance to an emergency, whether that emergency came in the form of tubercle bacilli or in these micro-organisms which are the cause of juxta-epiphysial osteo-periostitis. Before we try and see what there is in the epididymis which causes this to be, usually, the first starting point of genital tuberculosis, let me remind you, even the more omniscient amongst the youngest of you, that the origin of tuberculosis in man and also in animals is still often obscure, and that as we get older and know how little some of us know, it becomes us to be ready to say in answer to many questions, "I don't know," or "I am not certain." "Such and such may be a possible explanation." I wish you to bear this clearly in mind with reference to many of the suggestions which I shall place before you, and remember that, coming from me, they are often suggestions only. I will mention one instance of the obscurity which I mentioned. If, as a surgeon only, I may encroach upon medicine, I will remind you that I believe that there is no satisfactory explanation yet given to account for the frequency with which tuberculosis of the lungs attack the apices, According to some the explanation lies in the circulation of this part of the lungs being less active; according to others in the restricted movement of this part of the chest, owing to its being a more fixed part to support the shoulder-girdle and upper extremities. A third authority thinks that the fact that the apices are extra-thoracic, and therefore exposed to cold, is the explanation. A fourth, Dr. Campbell of Bradford, takes the same fact but draws a different explanation from it. He considers that the apex of the lung being extra-thoracic is subject to atmospheric pressure, and that in inspiration only a small quantity of oxygenating air reaches it. Any of the above explanations will account for the occurrence of catarrh, and retention of secretions and waste products, thus favouring the attacks of tubercle bacilli. But while all the above different explanations have been given, none is, I believe, considered to be completely satisfactory. If this is so in the case of one of the commonest tuberculoses, in which countless opportunities for necropsies by skilled hands have existed for years, it is clear that you must weigh well, before accepting them, any suggestions and explanations of the infinitely less common outbreak of tubercular disease in the epididymis. We come back to the question, What is there in the anatomy and physiology of the epididymis to explain its being the usual starting-point of genital tuberculosis? If you remember the physiology and anatomy of this structure, you will at once see a predisposing cause. The tortuosity and length of the epididymis is surely favourable to stagnation of its slowly-moving contents and to *adhesion*. You will remember the stress which I laid upon this stage of tubercle bacilli. The whole length of the seminal tubules has been roughly calculated to be no less than 900 yards; then we have the vasa efferentia, six to eight inches long, ending in little coiled masses, the coni vasculosi, which,

grouped together, form the globus major. Next comes the epididymis, elaborately coiled, especially towards its lower end, 15 to 20 feet in length, and lastly, the vas deferens, tortuous at its commencement in the globus minor, and sacculated and enlarged at its termination, about 16 inches in length. This great length of tube and the convolutions, tortuosities, sacculations met with at certain points along its course have one object amongst others, and that is to delay the course of the seminal fluid and so prevent its reaching too quickly the vesiculæ seminales, an object which is still further served by the sacculations and diverticula of the vesiculæ themselves. But it is clear that this wise provision for the slow movement of the seminal fluid may in those of poor vitality, much exposed to the bacilli of tubercle, defeat itself. A current, very slow at certain points, may stagnate, the epithelial lining of that canal may suffer, ever so little it may be, but enough to favour the *adhesion* of any tubercle bacilli which may be at hand.

Bardenheuer of Cologne, to whom we owe the operation epididymectomy, goes much farther in elaborating this point. He believes that tuberculosis always begins in the globus minor, and explains this by its dependent position and sharp bending of the vas, depressing as it leaves this portion of the epididymis. These facts, in his opinion, by their further retarding at this point the slowly arriving seminal fluid, explains the liability of tubercle bacilli to first lodge here. In this belief Bardenheuer is much too absolute. Within the last week I have seen a young man, æt. 27, a patient of Dr. Featherstone, of Tooting, who has a bilateral deposit in each epididymis, but while on one side, the most advanced, the disease is in the globus minor; in the other, the second to be invaded, it is as certainly in, and as far as external examination goes, only in the globus major. While the disease first shows itself in the majority of the cases in the globus minor, as far as my experience goes, though less in others frequently, the globus major shows the first sign of being attacked, and as we are discussing delay and stagnation of the seminal fluid as a possible predisposing cause, you will see in this diagram of the seminal tubes that the anatomy of the globus major also favours this, though to a less degree than the globus minor. These tubules, the vasa efferentia, run upwards as they leave the testicle and end in little convoluted masses, the coni vasculosi; both these small points are calculated to delay the passage of the semen in health, but in subjects weakly or run down and exposed to the bacilli of tubercle, this same physiological delay may become pathological and favour slight alterations in the epithelium, and adhesion of the bacilli. Bardenheuer points out that any delay of the contents in a mucous canal is liable, if prolonged, to lead to catarrh. You are familiar with instances. I will mention two. In the appendix cæci, if by inattention to food and action of the bowels, mucus and little fæcal masses, especially if the latter be hard, be allowed to linger, erosion of the single layer of epithelium readily takes place, the appendix is for a time blocked, and with the fermenting mucus and fæcal matter, becomes a veritable culture-tube. Another instance, gall-stones. The bile-ducts, like the appendix, have a limited calibre, a mucous membrane lined with cylindrical epithelium and capable of bringing about occlusion of the passage by swelling; unlike the appendix, they contain racemose glands. They are, therefore, additionally prone to catarrh, especially in women, usually stout, of middle age, fond of unsuitable food, often rich, taking little exercise, that will bring the healthy action of the diaphragm, ribs and intercostal muscles to bear upon the liver, which again is often compressed by tight stays. How easily in such cases will stagnation of the bile take place, followed by catarrh, and later by inflammation? Bardenheuer gives other instances, *e.g.*, obstruction of the milk ducts from a depressed or scarred nipple, leading to catarrh, later on to abscess; pressure on the ureter by a retroflexed uterus or by a parametric exudation leading to catarrh of this tube, catarrh of the kidney, pelvis, and even to hydronephrosis and renal calculus. Now, if a catarrh can be produced at certain points in the seminal tract, those points in which, as I have shown, physiological delay is especially provided,

it is clear that between the ages of twenty to forty, the time of chief activity and vascularity of the sexual organs, catarrh may easily be accompanied by congestion. Note next how readily congestion passes into inflammation. I have already mentioned Bardenheuer's instance of obstructed milk ducts leading to catarrh, congestion and then inflammation if pyococci gives access to the part. Remember the experiments of Boinecken bearing on strangulated hernia. We know that if a loop of intestine is caught, whether by a ligature or a band, or at one of the rings, it becomes congested, the veins especially suffering, fluid is poured out, in the case of a hernia, into the sac. For some hours this serous fluid remains sterile, having bactericidal powers. But if timely relief is not given, the serum loses these powers, the bacillus coli communis gains the upper hand, and being both patho- and pyogenic, the congestion now passes into inflammation and the gravest results may follow.

There are other suggestive points bearing upon the above belief that the bacilli of tubercle attack especially these points in the seminal part at which physiological delay is especially provided, this delay being prone to pass on into stagnation, catarrh, damaged epithelium, congestion and inflammation. First, there is the point already alluded to, the age at which this disease is most common, 20 to 40, those years in which the secretion is most active, and a block thus most likely to occur. Again, tuberculosis here is rare in children, and still more so after middle life, periods at which the glandular secreting structure is either not developed or in a stage of obsolescence. Secondly, there is the fact to which I shall refer again, that if gonorrhœa attacks the epididymis, the globus minor is its favourite seat, just where the gonococci find the mucous membrane most ready to become the seat of catarrh, congestion and inflammation.

I have spoken of the marked tendency of tuberculosis to attack both epididymes. Bardenheuer explains this fact, to which, as I have said, the English books do not draw sufficient attention, by the increased call on the function of the remaining testicle, the additional formation of seminal fluid. If these postulates of Bardenheuer's are granted, it is easy to see that the patient will run a risk of increased tendency to stagnation at what I have called the points of physiological delay, and so, if tubercle bacilli continue to be present, to their adhesion.

(To be continued.)

Surgery Extension Fund.

Guy's Hospital,
London Bridge, S.E.
October 6th, 1903.

Dear Sir,—May I ask for your kind co-operation in the endeavour to obtain £500 with which to provide an adequate waiting-room for the women and children attending our Front Surgery?

I enclose copies of my letters which have appeared in the daily Press. An encouraging response has already been received, but the fund is not yet complete, and the support of your readers would be very grateful to us.

A spontaneous contribution received from Her Royal Highness the Princess of Wales has had a marked effect in attracting attention to our effort.—I am, your obedient servant,

CONSTANCE M. MUDGE,
Surgery Sister.

The Editor,
"Guy's Hospital Gazette."

Abergeldie Castle,
Ballater, N.B.
September 29th, 1903.

The Lady-in-Waiting to H.R.H. the Princess of Wales is desired to say that, having seen Miss Mudge's letter to the newspapers about the proposed women's waiting-room at Guy's Hospital, Her Royal Highness has pleasure in sending the enclosed cheque for £10 to the fund.

To the Editor of *The Times*.

Sir,—I am permitted by the Governors of Guy's Hospital to ask you to allow your valuable paper to be the medium for an appeal on behalf of a special department of this great institution.

A simple statement of the condition of affairs will embody my position, and show the necessity for instant aid in the most practical way. The front surgery at

Guy's is the department in which all patients are first seen. It is the place where it is determined whether they shall enter the hospital as in-patients or receive continued treatment as out-patients. Our average attendance is three hundred patients each day; rather more than half of these are women and children. The room portioned off for their reception is not capable of accommodating more than twenty at a time, and there are often as many as sixty waiting to be seen. The only arrangement we can make for this extra number is to seat them on benches outside. During the summer time this is not very intolerable, but in winter time it is heart-aching work to keep women waiting in the cold, perhaps suffering from some very acute disorder, or worse still, the delicate little babies. There is no help for it, for though the worst cases are seen first, still the patients must take their turn.

What we want is a sufficient sum to build a waiting-room for the women's division; the plans are already designed, and if the work could be put in hand at once there would be some chance of a shelter for this overflow of suffering humanity. The ever-increasing population of South London puts more and more work on the hospital, and if the present rate is continued one dreads to think of the poor women and children still waiting in the cold of the ensuing winter. The cost of this room would be only some £500. It is a small amount compared with the vast fortunes which are existing, and which are sometimes given in charities, and a small sum which would represent so much comfort to the poor and needy of our very poor district.

Any donation, however small, will be gratefully acknowledged, and should be sent to the Secretary to the Treasurer, Guy's Hospital, S.E., and marked "Surgery Extension Fund."—I am, Sir, yours faithfully,

CONSTANCE M. MUDGE,
Surgery Sister.

Guy's Hospital, S.E.,
September 22nd, 1903.

To the Editor of *The Times*.

Sir,—With reference to my recent appeal in your columns for a sum of £500 with which to build a shelter, sorely needed for the protection from cold and wet of women and children attending the front surgery of the hospital, I shall be grateful if you will publish the following extract from a letter received this morning from a friend in the provinces who desires to remain anonymous:—

> "Although I have many heavy claims at home, I will offer £50, in fortnightly payments of £10, for this shelter, if nine other local rich people will do the same; or I will undertake to pay the £50 before Christmas next if the remaining £450 is subscribed by that date."

I earnestly trust that this generous incentive will quickly produce the desired result.

Donations should be sent to the Secretary to the Treasurer, Guy's Hospital, S.E., marked "Surgery Extension Fund."—I am, your obedient servant,

CONSTANCE M. MUDGE,
Surgery Sister.

Guy's Hospital, S.E.,
September 29th, 1903.

FIRST LIST OF CONTRIBUTIONS.

	£	s.	d.
H.R.H. The Princess of Wales	10	0	0
Mrs. F. Roget	100	0	0
Charles H. Goschen, Esq.	25	0	0
Jackson Hunt, Esq.	10	10	0
Henry Phipps, Esq.	10	10	0
Miss Potter	10	0	0
"Invalid, Leysin"	5	5	0
G. Haslett, Esq.	5	5	0
M. Hardy Voss, Esq.	5	5	0
Lady Belhaven and Stenton	5	0	0
Sir Mark W. Collet, Bart.	5	0	0
Sir William Eden, Bart.	5	0	0
Mrs. Farmiloe	5	0	0
R. E. Johnston, Esq.	5	0	0
Col. H. W. Noyes	5	0	0
Thomas Watson, Esq.	5	0	0
"G. E. R."	3	3	0
The Misses Hutton	2	2	0
C. G. Wood, Esq.	2	2	0
Mrs. Rolfe	2	0	0
E. C. Benecke, Esq.	1	1	0
Patrick Ness, Esq.	1	1	0
Mr. and Mrs. A. C. Oliphant	1	1	0
Miss Toller	1	1	0
Miss Oxford	1	1	0
"A. M. E. E."	1	0	0
"H. E. A."	1	0	0
Miss B. Hacon	1	0	0
Mrs. Moloney	1	0	0
C. T. Parker, Esq.	1	0	0
Miss H. Smallpeice	1	0	0
Other smaller sums	2	7	0

Papers by Guy's Men.

A Note on Tonsillar Enlargements and their Treatment. By Lawrie H. McGavin, F.R.C.S. Eng. Illustrated.—*The Lancet*, 26th September.

Two Cases from the Country.

I.

At the end of last year a farm labourer applied to me for treatment of a swelling behind and below the left ear, which he had noticed for several weeks.

His history was, that the previous year whilst in the fields on a hot summer's day, he felt a sharp sting on his neck. He rapidly put up his hand and caught "a large fly, black with red spots on its body." I paid, however, no particular attention to this story at the time.

On examination, the skin over the apex of the mastoid process was boggy and reddened, and fluctuation was obtainable. Except that there was no deep-seated tenderness, the appearance was very suggestive of mastoid abscess. Perhaps a week later I saw the man casually on the road, when pus was discharging externally through a small sinus. I then lost sight of him until last June, when the sinus was soundly healed, and he gave me the subsequent history.

Pus continued to discharge for some weeks, when one day, thinking that he felt something move, he slightly squeezed the opening, when out came a "grub" (evidently the pupa of an insect) from which he peeled the coat and disclosed a fly similar to the one he had caught on his neck nearly two years previously. The patient was an intelligent man, and I believe his story was correct in every detail. Evidently a species of gad-fly had pierced his skin and oviposited beneath it; the larva in due course hatching from the egg, and feeding in his subcutaneous tissues, eventually changing to a pupa, and (had he not anticipated the result) finally emerging as a perfect insect. He is certain that he was stung at a point quite two inches from the sinus whence the pupa was expressed.

Needless to say, this condition is very common in cattle (in which it is known as "warbles,") on those parts of the body from which the fly in the act of oviposition cannot be brushed off; and it is quite conceivable that an agricultural labourer or other person might be stung during heavy sleep or intoxication in the open air; but I have never seen another such case although I believe they are on record.

II.

During the first few hot days of the present summer, a tramp from Bristol who was uprooting ferns on the wooded slope of the Mendips opposite my house, felt a sharp prick on his finger, and on hastily withdrawing it, observed "a viper about three feet long" gliding away. Being fully aware of the dangerous nature of a viper's bite, he at once sucked the wound and walked across to my surgery, where he told his story. I saw the man within a few minutes of the infliction of the bite. He was an ill-nourished middle-aged man. He arrived, walking somewhat unsteadily, pale, and bathed in perspiration. On the third finger of his left hand were two small black punctures about one line apart. I immediately applied a tourniquet tightly round the arm, incised the region of the punctures, applied pure carbolic acid, and also injected into the wound a few minims of dilute Liq. Potassæ. By this time he began to be extremely faint and desired water repeatedly.

Constant sickness and watery diarrhœa rapidly reduced him to an exceedingly prostrate condition, the pulse becoming barely perceptible. However, Liq. Strychninæ mx. hypodermically and Ammon. Carb. gr. v., Aq. ad ʒi., by the mouth frequently, and repeated doses of brandy gradually improved the circulation. As he complained of colic, Pil. Opii, gr. i., was given which helped to check the diarrhœa and produce sleep. His condition was such that I found it necessary to remain by him all day, and by the evening he had not sufficiently recovered to walk, so he was accommodated in the stables, and a neighbouring farmer and his wife kindly undertook to sit up and take him milk and brandy every hour through the night. In the morning his arm was decidedly swollen, and a red lymphatic streak was visible, extending from the finger to the axilla. He was then conveyed to hospital by the Relieving Officer with the arm greatly swollen, and presenting, as I afterwards learned, lymphangitis of a hæmorrhagic character. He recovered a few days afterwards.

This case must have been an exceptionally severe one. At one time I should not have been surprised had it ended fatally. Probably the severity of the symptoms depended on the feeble nutrition of the patient, and the great heat of the prevailing weather, when the viper (the only poisonous British reptile) is in its fullest activity and power, and the poisonous fluid is proportionately more virulent.

Compton Martin, Somerset. B. B. GOUGH.
August 20th, 1903.

Parturition occurring in a Case of Paraplegia.

History.—About three years ago patient fell down some steps. This was followed about a fortnight later by weakness in the left leg, which increased gradually until about four months later she was unable to move the left leg. The right leg then began to be affected in the same way. Three months after the accident she aborted at the third month. Loss of sensation followed the loss of power, and both became gradually more profound, till at the present time there is complete absence of sensation and motion in the lower half of the body. One and a half years ago she had a full time child which was born with the aid of forceps. The gradual onset of the symptoms probably indicate that the injury had little to do with the lesion, and the case is looked upon as a syphilitic lesion of the upper neuron.

Condition on admission.—Patient is pale, there is a slight bald patch on the tongue and some scars on the knee. The breasts show all the signs of pregnancy at

term. The abdomen is rather flat with no tendency to bulge and the fœtus is lying with its back to the right, alive, with the vertex presenting. The vagina is vascular and the os is soft.

Nervous system.—Motor.—There is complete loss of power in both legs and spasticity is well marked on passive movements. The hands and arms are normal. The abdominal muscles at and below the umbilicus do not move on respiration.

Sensory.—There is complete loss of sensation to heat, touch and pain, from a line two inches above umbilicus in front, and below the level of the tenth dorsal spine behind. Loss of sensation to cold commences at a level of two inches lower down. No band of hyperæsthesia is present.

Reflexes.—The knee-jerks are greatly exaggerated on both sides. Ankle clonus is present and Babinsky's sign well marked. Even a slight stimulus of leg or thigh causes violent contractions of muscles.

Vasomotor.—There is partial vasomotor paralysis below the level of the anæsthesia.

Trophic lesions are absent.

The nerves and muscles react to the Faradic current. Nothing definite can be made out with the galvanic current, owing to excessive irritability of the muscles.

Micturition and defæcation are carried out in an automatic manner, and the patient is quite unconscious of the act. The power of micturition is strong.

The labour, May 14th.—At 4 a.m. the patient complained of some discomfort about the lower part of the abdomen. The membranes ruptured at 6.30 spontaneously. At 7 a.m. the os was fully dilated, and the fœtus was born at 9 a.m.

The patient lay quite quiet during the passage of the child, but moaned a little when the uterus was contracting. There was no attempt at bearing down, nor did the diaphragm contract during the pain apart from regular respirations. The abdominal muscles remained quiet and there was no sign of any increase in their tone. Beyond a sensation of discomfort at the lower part of the abdomen the patient felt nothing. The action of the uterus was strong but irregular; there was a slight caput succedaneum and the perineum was ruptured for about one and a half inches. The vulva became rapidly œdematous. Hæmorrhage was not abnormal, and the uterus contracted down well after the delivery of the placenta.

Progress of the case.—The involution of uterus and the lochiæ were normal.

Baby.—The child is healthy and fat, and there are no signs of syphilis. The mother's milk came in on the third day and the child thrives well on it alone.

This is a short account of a case which is by no means common. Dr. Armand Routh collected seven cases and read a paper on the subject before the Obstetrical Society in 1897. In Dr Routh's own patient the spinal cord had been severed at the sixth dorsal vertebra.

The case above was under the care of Dr. Horrocks, in Victoria ward, and he gave a prognosis that the child would be born without difficulty, an opinion which was fully realised. The most interesting points are on the whole physiological.

Here is a case of pregnancy occurring in a patient whose central nervous system was divided into an upper and a lower portion, and between which there cannot be any physiological continuity other than via the sympathetic chain. Yet all the physiological processes took place as in the normal being: the act of parturition below, and the act of lactation above, the former receiving its nerve-supply from the lower, and the latter from the upper portion of the bisected nervous system. Not only did lactation and parturition take place normally as regards their distinct purpose, but all the successive signs of pregnancy were present, *e.g.*, morning sickness, the changes in the breast, the fulness, pigmentation and the secondary areola: the uterus increased normally, and the fœtus was active and well developed in utero. The vagina enlarged, its mucous membrane became vascular and its secretion increased. Again, the puerperium was strictly normal, the milk good, and the amount excessive rather than low. The uterus involuted as a uterus should do, without the sign of any trouble to the mother. So regular and so painstaking does nature seem to be in endeavouring to leave nothing undone for the welfare of a child born by a mother who suffers from a disease which causes such profound changes in her existence.

The act of parturition itself was by no means normal. There was complete absence of uterine pain, and of the pains resulting from the stretching of the soft parts due to the absence of sensation. The contractions were violent, they were markedly irregular, and the progress of the child was rapid in the extreme. The help which is normally given by the accessory muscles was absent. This might seem to predispose to a prolonged second stage, but the second stage, on the contrary, was over in less than an hour and more than that the force of the uterine contractions was sufficient to rupture the perineum for one and a half inches. From this it may be inferred that one of the uses of pain in normal labour is to act upon and regulate the uterine centre, so that it should be guided by the conditions at the periphery.

It seems from a study of these cases that the whole phenomenon of pregnancy and labour must be determined by the metabolic changes taking place in the uterus, and that most probably it is the placenta which—possibly by some internal secretion—affects the blood, and that by way of the circulation such manifestations as the pigmentation of the breasts are brought about.

The central nervous system can have no determining influence, because this is practically in two halves in our case, nor can the ovarian secretions, for we know that both ovaries can be removed during pregnancy, the woman still go to term normally, and the functions of

the breast be well established. This has been confirmed by experiments on animals.

With regard to the nervous mechanism of uterine action, it is proved by these cases that the higher centres take no part in either determining the onset of labour, nor do they in any way play a part, except that of controlling to some extent the reflex centres in the cord, and also of receiving and interpreting the sensation of pain which occurs in normal labour.

It is well known that civilization and education tend to make a natural physiological process more difficult, and thus it is interesting to note that when the civilized mind is cut off from the lumbar uterine centre, that centre seems to revert to its old primitive way; in all the cases on record parturition and lactation were normal and the children strong and well, that is to say, that as long as the reflex arc of the lower neuron is intact, the birth of the child is easy without any other aid than that of the uterine muscle. Experiments on animals by Goltz go to show that not only is impregnation possible, but also parturition and lactation in a bitch whose lumbar cord is completely obliterated. This shows that the uterus of a bitch can act automatically apart from any connection with the lumbar cord in much the same way as the small intestines. How far this is due to the muscle or to the nerve endings, or what other factor determines the regular period at which parturition should come about, is a matter of speculation. There is no satisfactory case on record in which the lumbar centre, being put out of action by disease or injury, parturition has followed in the human being.

Another interesting point in the case was the large amount of lactose found in the urine. The urine gave an immediate and strong reduction with Fehling's solution. The ozazone of lactose was prepared and showed bundles of fine crystals. The morning urine was more loaded with sugar than that of the evening. The patient only fed the baby once during the night. The amount of lactose present was far in excess of that of the other normally confined women in the ward. The presence of lactose in so large a quantity raises the question as to where lactose is formed in the body, whether it is manufactured in and then absorbed from the overfull breasts, or whether it is formed in some more remote organ. Dr. Routh quotes some experiments by Paul Bert, which tend to show that after excision of the mammary glands in ewes, sugar was found in the urine immediately after delivery, and that this did not occur normally.

The amount of lactose present in this case varied, but the morning urine contained as much as 6·4 grs. per oz. The lactose was inverted by boiling with acid and dextrose obtained. The urine of normal women after labour only contains slight traces of lactose, even when the breasts are in full working order.

I have to thank Dr. Horrocks for kind permission to publish this case, and Dr. Philip Turner for so kindly doing the urinary estimation.

H. T. HICKS.

Guy's Hospital Students' Club Opening Dinner.

Held at the Club, on Thursday, October 1st, 1903, Dr. P. H. Pye-Smith, F.R.S., in the Chair.

The Dinner arranged to celebrate the re-opening of the Medical School for the Winter session proved a great success. Dinner was punctually served, and the tables were very beautifully decorated. The room was completely filled, and a long and pleasant dinner was admirably served—a great improvement on former years. Shortly after nine loud cheers greeted the rising of the chairman, Dr. P. H. Pye-Smith, President of the Students' Club.

The Chairman: Gentlemen, the first toast I have to propose this evening is one which is usually introduced with the statement that it needs no recommendation. I will not make the statement, but will leave you to accept it. I propose the health of "The King, God bless him!"

The Chairman: It is now my duty to propose "The Prosperity and Happiness of the Students' Club." (Applause.) I congratulate you, gentlemen, all of you, and the hospital, and the school, to which we all still belong—though some of us only by a somewhat attenuated link, yet one which we value very deeply. (Cheers.) And the causes of congratulation are many. In the first place, it has been my lot, from time to time since first this college was opened, to hear complaints of the culinary department—sometimes, it is possible, somewhat exaggerated; at other times, I am afraid, well founded. But all I can say is, that if you have habitually as well cooked and as good dinners as we have had this evening, there are no complaints possible. (Applause.) That is one great cause of congratulation. Another is, that during the past year there has been an almost unexampled—not quite, for nothing is quite unexampled in the history of institutions like ours—an almost unexampled series of successes all round. In the examinations of the University we have done extremely well—(hear, hear)—better, perhaps, than any school has ever done before. (Applause.) I will not say absolutely better than we have ever done before; but if not in every respect as high as in times when some very distinguished men alone won fame over all their competitors, yet for the extent of the success—and after all, that is the great point; because when a man of genius comes to a school, whatever the school is, he is sure to distinguish himself. If as a school we can send a majority larger than any other school for the preliminary and for the later examinations, then we have achieved the very best success we can have by showing that our average is a very high one. That has been the case this year; and I very heartily congratulate all those men who at these examinations have distinguished themselves so highly. As I have said, it is not only with mental equipment, but also with bodily strength and

skill that men make their way in the world; and it is a very happy thing indeed when with the healthy mind there is also the healthy, vigorous and manly body. And no one who knows anything of boys or of young men will doubt that an athletic youth is the usual prelude to a middle age of vigour and strength, and an old age of calm—peaceful and happy—decay. (Laughter and applause.) I can speak now from each point of view, and I trust that all of you, as I see you round me, rejoicing in the strength of youth, will enjoy the full vigour of manhood when in the midst of the absorbing, heavy duties of our profession, and at last may enjoy that serene happiness of old age—and may it be prolonged to all here—with that comfort which should accompany old age. That, I say, is to a great extent what is the reward of the strenuous cultivation of bodily powers in youth. And this year we have to congratulate ourselves upon, as far as I know, an unexampled series of victories gained by our men in the athletic field. (Applause.) In football of both kinds, in shooting and swimming, in cricket, in almost every kind of athletic sport we have done well: and I believe there was never an occasion when such a number of events were scored by any one hospital. (Applause.) Moreover, the development of our hospital and school, which changes grassy fields into bricks and mortar—but which we hope will, before many years, change again the bricks and mortar into grassy fields—has endowed our students with advantages which those of us who, long ago, were *in statu pupillari*, look back upon with envy. That splendid library, which we owe to the munificence of one of our governors (applause), and the great improvements in the accommodation and comforts connected with your life here, is a thing that we have all great reason to congratulate ourselves upon, and to congratulate you. The School, as well as the Hospital, is in a flourishing condition, and there is nothing which has done more, I think, to promote the happiness and well-being of the school than this students' club. May it long continue to flourish until even the successes and the triumphs of this year will pale before the greater successes and the greater triumphs of those who come afterwards! And when some of you look back, as I do now, on a series of years, may you be enabled to say that, good as the men are in this year, they were better still in every successive year. May this prosperity be only a prelude to some greater prosperity in the future! And I am sure you will join with me in wishing that success and prosperity may ever be the lot of the students' club.

The toast was heartily pledged.

Song, Mr. Felton.

Dr. Frederick Taylor: Mr. Chairman and Gentlemen, I rise with diffidence this evening, because on the last occasion on which I had the pleasure of addressing a company of those interested in Guy's, I fell under the lash of the Gazette for having been wearisome. (Loud laughter.) Now, I was very sorry to have been so, and I apologise for my past offences. Of course, on the present occasion, as you can well understand, I shall try to avoid anything of the kind. Brevity is the soul of wit, I know, and sweetness and shortness are probably associated together in the well-known proverb. But, all the same, there is something more important than wit, and that is, that we should do justice to those to whom we are indebted—(hear, hear)—and, even if that justice requires somewhat lengthy remarks, I think we may be pardoned for on such an occasion making them. I have to ask you this evening to drink the health of our guest, Mr. Robert Gordon, one of our governors, and one of the greatest benefactors to Guy's Hospital and Guy's Hospital Medical School. (Cheers). Mottoes are often rather ambiguous—Delphic, so to say. The motto of Guy's is "Dare quam accipere." Everyone can translate that in his own way. All of you know it is better to give physic than to receive it. I say it is better to give advice than to take it. Now, Mr. Gordon is not in the position of being required either to give medicine or to give medical advice; and, coming into connection with Guy's, he has no doubt felt the strength of the motto and the importance of it, and he proceeded to give in other ways. Mr. Gordon has not forgotten how to give. (Applause.) You know that very shortly after his connection with the hospital as a governor he took to heart the suggestions that the Rt. Hon. Arthur James Balfour made here four or five years ago, on the occasion of giving away the prizes, and he proceeded to endow a Research Scholarship and a Gordon Lectureship in Pathology—(loud cheers)—a lectureship which has borne fruit, and I hope will bear much more, and be the means of bringing about distinguished and valuable work in connection with the endowment of that lectureship. Then, Mr. Gordon has not been forgetful of the needs of the hospital, not only in the form of what I may call solid cash, but also in the construction of some of those balconies which we see going out in every direction—(applause)—a move which is exceedingly valuable to all in the direction of the latest observations and the latest requirements of medicine and surgery. I am sure everyone must be most thankful to him for his assistance in that way. One might refer to other mottoes in connection with donations: *Bis dat qui cito dat.* I am sure Mr. Gordon is cito dat and bis dat several times over, and I am also sure we are always grateful to him for the way in which he has shown his intense interest in everything connected with Guy's Hospital. (Applause.) I ask you to drink his health, with "three times three," and any other things which you may think it necessary to do.

The toast was enthusiastically honoured to the singing of "For he's a jolly good fellow," and three cheers.

Mr. Robert Gordon, in responding, received a rousing cheer and said: Mr. Chairman and Gentlemen, I am obliged to confess that words fail me in my effort to properly express the thanks I feel for the compliment you have paid me. I wish to thank Dr. Taylor for the very kind words, far too complimentary, in which he has proposed my health, and you, gentlemen, for the very cordial manner in which you have responded to the toast. I

feel now that I am one of Guy's. (Loud cheers.) I have had the honour of being a governor for a few years, but I have not come into the inner life, if I may so express it, of the hospital until this evening, when by the cordiality of your reception I find I am indeed regarded as a friend of the hospital and one of your brothers. (Cheers.) I am inclined to envy you gentlemen the privileges which you enjoy when I see, as I do from time to time, the work which is being done in the hospital, a work which is very very great, very very valuable, and in every way I may say indispensable. But there is another work being done here, which is that of educating for the profession those young men who come forward determined to make it their life work. You have here, I suppose, greater facilities, or certainly as great facilities, as can be found anywhere in the world for acquiring a thorough knowledge of your profession—(cheers)—and it must be in a very large measure your own fault if you go out at the end of your term here unworthy of the hospital from which you have graduated. You ought to go out, every one of you, with the Guy's mark upon you, hall-marked as the pure article by the manufacturer. (Cheers.) I say I envy you because I have seen something of education in my young days, and I recognise the marvellous change which has taken place, I will not say so much in your profession particularly, but certainly in ordinary education. We are getting now a very great deal of education, we hear a great deal about it; I speak of education as it is practised just now, and there is too much cramming, and sending out into the world thousands and thousands with a mere smattering, if I may so express it, of education; no solid ground work and no thorough grounding. There is no attempt at future study, but a cramming to enable them to pass a certain examination in a certain number of subjects and to pass sufficiently well to earn a grant, the grant upon which the teachers depend for their support. We do not want any smattering in Guy's, we want the good solid article, so that when you go out and people call in Guy's men, they may know they will be well treated. A friend said to me, when he knew I was coming to this dinner, "I hope you will have a good time, perhaps you may meet Bob Sawyer and Ben Allen." (Laughter and cheers.) But I think he must have forgotten that those gentlemen graduated a long time ago. The Bob Sawyers have to a very large extent passed away, and we do not now find it, as a necessary concomitant of the newspaper report of a row "a large body of medical students were prominent in the fray." Medical students are no worse than their neighbours. I do not say there is not a certain amount of animal energy which must be worked off, but you have now opportunities of working it off such as earlier students had not, in the very admirable recreation ground which attracts so many. I have never played cricket, I have never played football, and, strange as it may appear for a man of my age and comparative leisure, I do not even play golf. I cannot play golf, or tennis, or chess, or the various other games, all of which I see occupy students in their spare hours; but I am none the less interested in what goes on there; and I read with great satisfaction from time to time in the GAZETTE, which they send me with great regularity, the various triumphs which are won by Guy's students. I take great pride in seeing that they have won all those prizes. I saw with great satisfaction the beautiful array of cups which you have carried off this year, and which are very numerous, and reflect great credit upon the executives of the clubs. I have kept back several of the remarks which I had intended to make, for Dr. Pye-Smith anticipated me, and I would not inflict them upon you a second time. A few days ago I came across a proverb or saying which rather struck me. It was this: "Speeches can never be made long enough for the speaker, or short enough for the hearers." We do not want to have any too long to-night, but it recalls to my mind a little speech which I heard on one occasion, and which corresponds admirably with that saying. It was at a Scottish society in New York, where they have to elect year by year managers to look after the affairs of the society. One year they elected as manager a nice old Scotsman, a New York florist. He had never held office before, and he was immensely pleased with the compliment; it tickled him to death, as they say. The day came for the annual dinner, and in honour of the occasion he decorated all the tables with plants in a very tasteful manner. We were all very much pleased, and thought it was very nice of the old gentlemen to do this. After the loyal toasts and the other toasts of the evening had been proposed, one gentlemen got up and proposed the health of our old friend, speaking of the very nice way in which he had decorated the tables, and so on. He was a very modest old man; he got up and said in Scotch: "Gentlemen, I just bow my thanks," and then sat down. It was the speech of the evening; it was received with great enthusiasm, and I do not think there was a happier man in the company than he was to find that he had been treated so kindly. I will take example by him and make no further remark except "I bow my thanks." (Loud applause.)

Song, Mr. Ellis.

Bassoon solo, Mr. Black.

Song, Mr. Felton.

The TREASURER (Mr. H. Cosmo Bonsor)—Mr. Gordon and gentlemen, I speak to-night as a member of the students' club. (Hear, hear.) I believe I was once a student. I am afraid I have forgotten all that I ought to have learned, but one thing I absolutely recollect, which was particularly impressed upon me was, that I was always to obey the advice of the medical profession. This summer I happened to go for my holiday to a fashionable watering-place. I naturally consulted the eminent physician there. After having looked over me, and the rest of my family (laughter) he assured me that we had only one failing: it was that we did not drink enough. (Renewed laughter.) I have never ceased to wonder why that gentleman is so especially popular. I am endeavouring to follow his advice. I recollect very

well when the object of my toast, Dr. Pye-Smith, our chairman to-night, once gave me most excellent advice. It was shortly after I became treasurer of this hospital. He advised me not to allow the hospital to get into debt. (Laughter.) I am sorry to say that I did not follow his advice, and, for my own personal convenience, I have regretted it ever since. But, gentlemen, after all, though it would have been infinitely more comfortable had I followed Dr. Pye-Smith's excellent advice, I believe it would not have been for the good of the hospital, and for the good of the school if we had not launched out into heavy expenditure. I think that to-day, if I may say so, the well-being of our hospital and the prosperity of our school is assured; and that whatever may happen in the future, one thing is certain, that Guy's will take the lead among the medical schools of the world. (Cheers.) In listening to Dr. Pye-Smith's speech just now I noticed he said it was only a slender thread which bound him now to Guy's Hospital and Guy's School. Gentlemen, I take the greatest exception to that remark. (Hear, hear.) I believe, whatever Dr. Pye-Smith may think, that the thread that binds not only the governors, but the students of this hospital to their consulting staff is no mere thread, but a lasting bond of affection. (Cheers.) In proposing Dr. Pye-Smith's health, I can only remind you, gentlemen, of the services which you individually have known that he has rendered to this hospital and to the suffering humanity which this hospital contains. But my recollection goes back to the days when I first became a governor of this hospital, when it was Sir Henry Howse and Dr. Pye-Smith who bridged over the distance which seemed once to separate the governors from the staff of this hospital. It was greatly owing to his tact that the governors and the staff of this hospital came to acknowledge that they had one common end—namely, the advantage of the sick and suffering who come to this hospital, and the advantage of promoting medical science, which was to be of such great use throughout the world. I shall never forget, in those early days at the meetings that I attended as governor, Dr. Pye-Smith's calm tactful manner, and the way he dealt with the difficulties that existed and the enormous benefit he rendered thereby not only to this hospital, but also to the City of London, and to all who were concerned in its hospitality. (Cheers.) Gentlemen, Dr. Pye-Smith is bound to us by no slender thread. We recognise thoroughly the great maxim that pervades the being of Guy's Hospital, that so soon as a student enters our school he becomes one of Guy's, having appreciated the fact that he has joined one of a great community bound together by ties of good-fellowship, bound together by one common cause, namely, to do their best to promote the science in which they are engaged, and to alleviate the sufferings of mankind. Dr. Pye-Smith is so well known to us all that I do not intend to add a single word to what I have already said, except to express the hope that he may long live to enjoy the friendship and fellowship of the men that are still to come to Guy's Hospital, that he will consider himself always welcome, thoroughly welcome, whenever he enters the portals of Guy's Hospital. (Cheers.) I ask you, gentlemen, to give to Dr. Pye-Smith the honours of being an excellent chairman and a dear old friend. (Loud cheers.)

The toast was musically honoured with great enthusiasm and loud cheers.

The Chairman, in reply, said: Mr. Bonsor and gentlemen, let me express very heartily how deeply I feel the very kind and generous words which you have just used, and the feelings with which they have been received. I never meant that the connection I have with Guy's was slender in anything else than the duties and the frequency of my work here. Sir, affection and interest and devotion to the hospital and the school, and to all the men connected with it, will never be anything else but the strongest feeling at my heart. (Cheers.) I have noticed in the short and admirable speeches which we have listened to this evening, that there is a strong tendency to epigram. Our friend the senior physician gave us two or three admirable epigrams, and, I think, all in a learned language. (Laughter and applause.) And this evening our benefactor, Mr. Gordon, made an epigram in another language which to me is still more unknown than Greek; but it was very much to the point. And you, sir, gave us an epigram which will, I doubt not, long be remembered; and everyone who is looking forward to the days in which he will shine in fashionable practice will remember—and the words will go into every household—that whatever you do, be sure you drink enough. To follow up the example set me, I will give you an epigram in a language as learned as Dr. Taylor's or Mr. Gordon's, and it is a definition of what an epigram should be:—

"Omne epigramma sit instar apis, sit aculeus illi, sunt sua mella, sit et corporis exigui."

Or for the benefit of those who are not addicted to reading Guy's Hospital Gazette, let me put it into English, or attempt to do so—An epigram should be a little thing, like a bee, with honey and a sting. And I will conclude with an epigram with which I was greeted by an American patient who, when paying his fee, grumbled at the peculiarity which we are all familiar with, and which he expressed thus:—

Pray can you tell me why
You physicians take
A guinea for your fee though
You no guineas make?

And the answer I gave him was:—

Oh yes, the reason's plain
We're loyal and unwilling
That our sovereign e'er again should be
Left without a shilling.

One more adage is ascribed to Alfonso of Aragon, surnamed no doubt for this reason "the wise"—

Old wood to burn,
Old books to read,
Old wine to drink,
Old friends to love.

(Loud cheers.)

Auld Lang Syne and the National Anthem concluded the proceedings at 10.20.

Passim.

The first meeting of the Physical Society, whose origin is lost in the fabulous days of the eighteenth century, and whose end is not yet, will be held to-night, October 10th, at 8.30. Dr. Goodhart will deliver the first address on a subject with a title characteristic of the author —"Pitfalls." There will be a dinner previously in the library, at which the price of tickets will be 3s. The usual dinner will also be supplied at 1s. 6d. No wise man of any year will miss this unique opportunity of hearing a lecturer who always combines an appeal to the intellect and the sense of humour with sound practical dogma, and many well be personally glad to welcome our venerable President and our youngest Consulting Physician.

The Annual Dinner was well attended, and we were glad to see so many old faces and so many new ones. We offer as a suggestion that another year a table might be set apart for Freshmen, who otherwise are somewhat lonely, and that the Cups might grace the table instead of lurking in solemn grandeur in the locked-up smoking-room.

Rarely, if ever, has wisdom been so justified of her children as the criticism on Prize Day speeches. We are free to say wisdom, because the voice was that of our official reporter on that occasion, though the auspices were our own. The speeches on the opening night were scholarly models on classic lines of all that speeches may be at their best, compact, clear and interesting, and we fancy our readers will enjoy their perusal. To Amurath succeeded Amurath, epigram, apothegm and wit rained on our astonished ears, and a serious jealousy was detected between the rival expounders of classical learning, while Mr. Gordon capped them both with his Scotch quotation; but naturally such speeches as his and the Treasurer's need to be heard to be most fully appreciated, as intonation and the Scotch *dialect* are but feebly expressed on paper.

Throughout the evening a tone of gentle raillery at the Gazette was noticeable, and oft we glowed with conscious pride and oft observed the manager blushing. We learned on most irrefragable evidence that the Governors and the Staff do actually read the Gazette, and Mr. Gordon added more—that it was sent with the greatest regularity! With regard to the criticism on the Prize Day speeches, we were fain to turn up the paragraph and find that it generally condemned the length of the speeches. Now it is generally conceded that the speeches of the Governors and of the Staff are of an exceptional high standard and of great interest, but though there are at least thirty politicians whose views we should enjoy, listening to those thirty in succession would clog the most ardent appetite, and that was the case on Prize Day. Needless to say, we meant no discourtesy to the speakers nor disparagement of their speeches, which, as all who run may read and verify, were excellent in matter and form.

The change most noticeable was the dwindling of the oratory. The actual speeches were in form so admirable, but if anything they erred on the side of brevity. We trust we shall not be blamed for this, but altogether they did not take an hour, with frequent musical interludes. The disappearance of the student element in the speeches is a great retrogression. From time immemorial the voice of the President of the Residents has been heard by the awed freshman in a short, frequently studied, but invariably interesting speech, and we have even heard the Editor too. Be that as it may, we hope the position of the President of

Residents will not be overlooked another year. Many will remember the inimitable and popular speech made by Mr. Durbridge some few years back in proposing Dr. Hale White's health.

The disappearance of the Physical Society Meeting after the dinner has left the evening somewhat blunt ended, and we think has reacted on the attendance somewhat. There were fewer of the "past" present, though the attendance of dressers and students was exceptionally large. Perhaps the loss of the after-dinner address and conversazione and also of the microscope and instrumental display has been a mistake. Be this as it may, we find that the correctness of the evening, perhaps even the accuracy and foresight of the arrangement too, tended to give rise to the criticism we have heard that the evening was a little dull.

The freshman has doubtless read his lay sermon and found his way into the various recesses of the Club. We are now prepared to briefly indicate the practical line of duty he will feel himself bound to ensue. There are industries for all; see that they are filled. There are four Rugger teams and three Soccer teams to be loyally and steadily supported; there are Physiological, Debating, and Physical and Dental Societies to which you must add your mite. If you do not play football you can run across the country, or write papers for the societies. Every man has his hospital's interest to support, and we look confidently to the present generation to fill the places of those who have left, particularly in the Football and Cricket XI.'s.

The existence of so many teams naturally requires great skill to avoid trouble. It is impossible for the teams to be filled if the members scratch at the last moment. We would suggest that understudies be posted in each team, and that it be forbidden to take any understudy after Friday night, and we suggest to all not to make the arduous and thankless work of the secretaries harder than necessary if any sacrifice on their part can save it.

The Council of the Clubs' Union have decided to apply for a grant to build a stand at Honor Oak for the spectators. Few details were available so that the scheme could not be discussed in detail, but its reception was very friendly. There were two courses open—to loan the money on security of the receipts, or to present the money. It was not stated whether it would be proposed to charge members of the club for the use of a stand on their own ground, a perfectly legitimate but somewhat undesirable proceeding, or whether the receipts from the outside crowd will alone be sought; if so, we fear they will not be large. If the money, or any part, is given it would naturally be clogged with the condition that Guy's men and lady friends go in free. Personally we doubt the probability of a gate even being worth the outlay from a financial standpoint, but we agree most heartily that it is most desirable for the ground.

The question arises, as it has arisen before, why the United Hospitals Football Clubs should take so large an interest in the gate of the Cup ties. The Cup ties are rightly played on the admirable grounds at Richmond, but why should not the struggling Clubs' Unions, amalgamations, and so forth, of the hospitals reap a share of the gate they have created? The United Hospitals possesses large sums (one treasurer even preferred the balance to his future as a medico and so saved his successor from responsibility), but a good deal is spent without adequate return, *e.g.*, Paris trips, while the funds that are contributed by the members of the contending hospitals to see their own men play are lost to the clubs themselves. May there be a successful agitation

in favour of dividing a large proportion of the gate and sheds receipts between the contending hospitals. Let us hope the finance committee will look to it.

We regret to have to record the death of our only V.C. of the present time (W. J. Maillard) who died at a comparatively early age, but it is a safe thing to say that many others have done equally valiant deeds without the luck to draw official notice. Doctors in the Crimea and elsewhere have frequently been awarded the most coveted and valuable distinction, but there is little doubt that the loose method of awarding honours in the last war, while it detracts somewhat from the value of the modern decoration, enhances that of those won in the sterner and more critical times gone by.

Mr. Philip Turner having reverted, by the grace of the Medical Committee, to his first love—surgery, to wit—the vacancy of Medical Registrar has been filled by the appointment of Dr. H. Barber, who thereby establishes an unusual record. He has just ceased to be a H.-P., and, in addition, he has vacated the command of a winning Cup Team at Association and at Cricket. He has surpassed the "Soccer" men in skill, has easily headed the cricket averages, and has, in addition, established a new record for the Final Cup Tie and for the first wicket. With all this he is still eligible to play for us in Cup ties. His appointment is most deservedly popular, and we are confident he will enjoy a large and appreciative following.

With regard to the latter point, we have received grumbles about the numbers of men who go round with the Registrars, including, as they often do, some dozen or twenty qualified men doing post-graduate work. There is no denying the clerks are somewhat eclipsed by the crowds that are attracted by the very excellent teaching, but surely if the Registrar is teaching the clerks, it cannot, or *ought* not, to be profitable to the qualified man, and if he is not teaching the clerks, he ought to be. Some attempt to concentrate questions and attention on the clerks, leaving the others in the position of auditors, but certainly we should very much have resented our callous ignorance being exposed in that way, and we doubt if it is a good way for beginners, however thick-skinned. However this may be, we think that it should be decided whether or not it is desirable for the present state of things to continue.

Dare we suggest that the official who presides over the advertisements of the Physical Society might have been a little more explicit in his announcement of the subject of Dr. Goodhart's address? Who is, or who was Pitfalls? The name sounds like that of a German scientist—but then, surely there should be only one l, and a judiciously placed diæresis might give it that finish which, as a Teutonic surname it would seem to need.

Another quidnunc cheerfully reminiscent of the lecturer's last paper supposed that it might be "Round about the cæcum" or a "Romance of the appendix," and it may be that the well known difficulty of this subject will afford a theme to the distinguished lecturer.

There is another interesting speculation excited. At what period of a career can a man confess to mistakes without secretly exciting a sneer in the listener's mind? Judging by literature and lecture no one ever makes anything but a perfectly justifiable error and the discrepancies between the prophesies and the event are charitably dealt with by most demonstrators who themselves might say with Dido, "Non ignara mali miseris succurrere disco," when the unexpected is revealed.

In general the confession of error as related by a frail but excessively human mortal not only is somewhat palliated in the recounting, but frequently is made to redound still more to the credit of the culprit. This is an easy but most unprofitable form of error. In practical medicine no one learns from anything but his mistakes, and those who can glibly explain, palliate, and excuse, learn least. Moral courage is the rarest of all virtues, and nowhere is it more admirable than when it leads a man to expose his errors boldly for the instruction of his pupils, and we may say nothing redounds more to his credit nor gives his reputation more stability. The man who has made a "howler," whether he be an H.P., A.H.S., or in a more exalted place, really only provokes contempt and ridicule by evasion.

We should like to call attention to the opening meeting of the Debating Society, to be held in the smoking-room on the evening of Saturday, October 17th. The President, Dr. Savage, will occupy the Chair, and the debate, which is to take the form of a vote of no confidence in the Government, should be a highly interesting one, and well worthy of this Society's high traditions. It is to be hoped that freshmen will make a point of being present, and that of those who do attend there will be more than a few speakers. The Society is nothing if not a representative one, and the idea that the floor of the house is the monopoly of the senior men is totally erroneous. In the nature of things, the first plunge into articulate speech among an assembly of those who are at present strangers, is a difficult undertaking; but the maiden speakers are by far the most acceptable to all active supporters of the Society, and so it is to be hoped many will see the wisdom of learning the gift of intelligible expression of ideas, which is nowhere easier learned than in the Debating Society of Guy's Hospital.

The appeal that Miss Constance Mudge (Sister Surgery) has issued, with the consent of the Governors, has been most favourably received by the papers, and its progress is noted elsewhere. There can be no doubt of its extreme urgency in the near future. It is terrible to contemplate the suffering that waiting as at a pit door inflicts on those who are ill, and we congratulate the Sister most sincerely on her pluck and energy, qualities familiar to those who have worked in the surgery. Her Royal Highness the Princess of Wales *ultro accedit urgenti*, and her unexpected donation has led to other supporters.

There is a side light on the donation that is perhaps interesting to record which explains in part Her Royal Highness's interest. Princess May as most observed in her visits to Guy's is no ordinary visitor but a keen expert and a candid critic. Advancing unexpectedly into the Surgery on her last visit she encountered a familiar but disgusting horror—a man with a large bleeding scalp wound being dressed under the eyes of other patients, and her words of condemnation of the scene were unstinted and generous. Now that these things are being reformed as far as money can go, we surmise that her knowledge of the need has led to a subscription to that end. Would that all critics were as practical and as generous as Her Royal Highness.

Characteristically one answer came unsigned, stating that if the Sister would take the money that was used in torturing dogs there would be no need to appeal!!! Surely there are none who really believe that absurd and oft-refuted libel. Why is it that the "anti-leaguers" lose their refinement and manners in controversies?

An interesting case of tannic acid poisoning occurred in the Borough recently as the result

of an accident, and eventually resulted in an inquest, at which the enquiries revealed that the workmen took tannic acid as "a tonic" frequently. A witness with more regard for his trade than the truth, following a line familiar to us under a weaker Coroner, had the audacity to suggest that the symptoms of irritant poisoning were due to the *faulty treatment* adopted at Guy's after admission (treatment of which he knew nothing). Somewhat to his surprise he found a different Coroner in control and also, we are happy to say, a "good witness" in the H.-P., and this impudent attempt to transfer the man's death to the shoulders of the doctor was a hopeless failure.

The Matron has brought about a most admirable innovation that has long been on her mind, namely, the institution of a course of post-graduate lectures to Institute nurses, and shortly a series of medical and surgical lectures will be given by an H.-P. and H.-S, while Mr. Bellingham Smith will continue his gynæcological lectures. By this means it is hoped Nurses on the Private Staff will have an opportunity of keeping abreast with modern treatment and requirements. Perhaps the greatest need of private nurses is the practical knowledge of antiseptics needed to compress properly over night and to manage instruments and ligatures at the operation, things which are a sealed book to many from a lack of opportunity.

This is not strange considering that some Head Nurses have never even been in a theatre at an operation, and others only four or five times, and then by accident. The Sisters have a most unthinking disregard of the necessity for training their nurses in the details of a theatre. It results in great unhappiness when a Sister is out and an operation has to be taken for a nurse who is entirely a novice in a theatre however skilled in theory. In fact the care so many Sisters take to avoid any nurses accompanying their cases into the theatres seems somewhat selfish and not so much based on the exigencies of the ward as on the senseless traditions they have received.

Oh, those telephones! No grumble has been uttered in print hitherto in the long weary sixteen months since the old system was hastily disestablished and disendowed in favour of the fitful chaos that has prevailed ever since. Repining is useless. The electrical engineers are full of hope and of the details of yet another system; but it is sixteen months since *reliable* telephonic communication has been available, and the inconvenience has been enormous to patients and to residents, and most of all to the Nursing Staff. The telephones and the medical lift act like Hyde Park to the agitator—they attract all the bad language in the hospital and serve as lightning conductors for criticism.

There is a proposal which all men will agree to that facilities should be afforded for the Nurses to use the Gymnasium, and that Massage Classes should be instituted. We think these are splendid ideas, and hope to publish an outline in our next issue.

Nursing News.

Matron's Office.

On September 29th, Nurse Watson left the Hospita on completion of her three years' training. Probationer I. Thomas has been appointed to succeed her as Head Nurse in Addison Ward.

On September 15th, Probationer Mortiboys was appointed Head Nurse in Bright Ward.

On October 5th, Nurse Ripley left the hospital having completed her three years' training in August last.

To the October Freshers.

SALVE.

Now, Welcome! Yea, thrice welcome,
Ye Freshmen, one and all!
Pass in through opened portal!
Pass in please, great and small!

Come here to me, my little friend!
I'll take you by the hand;
But on your best behaviour
You must, remember, stand!

For here most of the Nursing Staff
With downcast eyes flit past;
Please keep your eyes averted;
To look at them is "fast."

Until you know your way about
The place, I'll be your guide,
And if you're at all nervous,
Take heart! I'm at your side.

Mark the beauties architectural
Of Hunt's Buildings, front and back!
(I hope you saw on ent'ring
Our yellow chimney stack.)

Peep in! See cabalistic
Signs such as M.O.P.S and W.O.P.S!
Sniff up the all pervading,
Ever present scent of hops!

The stately pile upon your right
No doubt you have observed,
For sacred 'tis; 'tis "Clinical,"
For choicer souls reserved.

And here we are at th' iron steps,
Up which you now must climb,
To reach the State Apartments,
To be seen one at a time.

"'Tis the Bank of England Counting House,"
Awestruck, you well may say,
There's just one little difference—
The paying 's all one way.

Fees paid, you've full permission
To strut the Colonnade,
Or munch the buns provided
By good, kind Mr. Wade.

And finally we'll hand you,
With our blessing to the care
Of the "gent wot runs the 'orspital"—
The old Commissionaire.

H.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Guy's Hospital Physiological Society.

Dear Sir,—Through the medium of your columns may I be permitted to remind men of the meetings of the above society. These are held on alternate Thursdays at 4 p.m., when a paper is read on some subject, generally of physiological interest. A special invitation is offered to anyone—freshmen especially—interested in physiology, to attend. The general meeting will be held on October 15th. Further particulars will be posted up.—I am, yours truly,

W. H. MILLER, Hon. Sec.

Rugby Football.

Dear Sir,—With the coming of the football season it is the custom to give the old members and freshmen, especially the latter, a word of advice. To the old members, let me just exhort them to show again their old keenness on and off the field, and to the freshmen to follow in the footsteps of their seniors. Unfortunately, we have lost five of our last year's XV., but we look to the junior teams and to the freshmen to fill up these vacancies and to make the old "Blues" play hard to keep their places. Our ground, about the best in London, is near the hospital, so that there is plenty of opportunity for training. To this fact and to the "Guy's" keenness we undoubtedly owe our present high position in Rugby football and our successes in the Inter-Hospital cup ties. There are two trial games on October 3rd and 7th, especially got up to discover "new blood," and it is in these games only that the merits of the various "freshers" can be judged by the committee. There are four XV.'s run every Saturday, and these teams are posted up in the Front on the Thursday. It is hoped that the Saturday morning scratchings will be absent this year.

Guy's jerseys and other football accessories can be obtained at Lewin's, Crooked Lane, City. To sum up, let us have keenness, training and good-fellowship, and we can confidently look forward to repeating our great victories of last year, and to continue our successful career in the Cup Ties.—Yours, etc., E. MORGAN.

Appointments.

CIVIL.

Griffiths, D. R. T., L.S.A., has been appointed House Surgeon to the County Infirmary, Brecon.

Swan, R. H. Jocelyn, M.S. Lond., F.R.C.S., has been appointed Resident Surgeon to St. Peter's Hospital, Henrietta Street, Covent Garden, W.C.

Looking Back.

Curious Calculations extracted from an Article on Homœopathy inserted in the *Medical Gazette*, 21st February, 1840.

Let us take "Opium," the drug said to have been ordered by the Homœpathic Physician for the late Mrs. N—— (on whose body an inquest was held).

The dose of opium recommended by Hahnemann is two DECILLIONTH parts of a grain. This sounds mighty simple, and until we look more narrowly at the power of numbers, is not so monstrous; by mere volition it is impossible to conceive so minute a division of matter: But an Unit, with *sixty cyphers* in its train, is in reality, a formidable number. Persons have illustrated the absurdity of homœpathy, by recommending the throwing a grain of medicine into the Thames; they meant to exaggerate, but in fact, had they substituted the Atlantic Ocean, for Father Thames, they would have enormously underrated the degree of attenuation: as I will now proceed to shew.

The diameter of the earth is about 8,000 miles; the solid contents of spheres vary as the cube of their respective diameters. The population of the World has been calculated at about 800,000,000; and a homœpathic dose of opium amounts to two decillionth parts of a grain: Upon this data we proceed.

℞. From one grain of opium abrade an atomic particle which shall bear the same proportion to the whole grain that a spherule one-thousandth part of an inch in diameter bears to the globe on which we stand. Divide this particle among the whole population of the world, cause each individual to swallow an homœpathic dose every *second*, and it would require 20,000,000 of years for them to swallow the particle described. I ask the reader to ponder on this for a moment, and then read the following quotation from Hahnemann's "Organon of Medicine" note, §283: "I have often seen a drop of the Tincture of Nux Vomica at the *decillionth* degree of dilution produce exactly half the effect of another at the quintillionth degree, when I administered both one and the other to the same individual, and under the same circumstances;" and then he gravely tells us "if the patient is very sensitive, it will be sufficient to" —what does the reader imagine?—"to smell a phial that contains one of these globules." "After the patient has smelled to it, the phial is to be re-corked, which will serve for years." And this, sir, is the apostle followed by gentlemen who have been "educated in the common notions of medical science;" of whom Dr. Quin's list published several years since contains upwards of 300!! One further illustration and I will cease. Opium is a potent drug; let us take "capsicum," which many of us eat rather *allopathically*. What dose of this does the leviathan of homœpathysts recommend? He would give one trillionth of a grain—This is given either in a globule of sugar, or a drop of Spirit of Wine. Let us take the latter as the vehicle. Suppose we wished to attenuate one grain of capsicum, how much Spirit of Wine does it require, allowing one minim for each dose?

The area of the great Pyramid of Egypt is 485,250 square feet; and its height 499 feet, say 500, its solid contents are therefore 80,041,666 cubic feet. Say we have 378,875 minims of Spirits of Wine in a cubic foot, divide the trillion by this number, and the result is, we have above 2½ billions of cubic feet in a trillion of minims: extract the cube root, the result is 13,750 in feet, which will be the length of each side of a cubical vessel which will hold a trillion of minims of pure spirit, *i.e.*, it must be above *two miles and a half long, two miles and a half wide;* and *two miles and a half high;* or comparing it with the great Pyramid, it would require above thirty-two thousand, six hundred Pyramids to contain Spirits of Wine to dilute one grain of Capsicum, Thus Sir I have presented you with an accurate description of the homœpathic doses of Medicine deliberately recommended for the cure of disease, &c.

By THOMAS H. SMITH.

Practical Nursing Points on Rectal Feeding.

If the nutrient enemata are to be retained, and rectal feeding is to be a success for any length of time, it is imperative that the lower bowel should be well cleared out and kept clean. Unless the nutrient enema follows directly on an abdominal operation—in which case the bowel has been emptied beforehand—a large soap and water enema should be given, or in cases where this is not desirable, one and a half pints of saline solution or boracic lotion should be injected with a Higginson's syringe, and this irrigation should be continued daily. By this means, the debris of the nutrients is washed away, the unpleasant smell so often noticed about patients on rectal feeds is entirely absent, and the patient finds little difficulty in retaining the food.

The best method for giving enemata is by catheter and funnel. The ordinary No. 8, 10 or 12 soft rubber catheter, with the barrel of a four ounce glass syringe does as well as anything. If more pressure is needed a piece of tubing can be added, but in most cases it is not necessary. The ball syringe has died a natural death; it had few points to recommend it; it was very dirty; almost impossible to clean properly, and quite impossible to see if it were clean; it was an awkward instrument to handle, and it was very difficult to avoid disturbing the patient considerably and losing part of the fluid in the bed when giving the enema. The soft catheter is easily passed; it can be inserted eight or ten inches in the rectum without any fear of injury. The flow of the fluid can be regulated by pressure, and there is a very small chance of air being injected.

If there is difficulty in getting the fluid retained, the pelvis of the patient can be raised by a firm pillow under

the buttocks, or the foot of the bed raised on blocks, but as a rule this is unnecessary. The patient retains the enemata if it is given slowly and steadily and with all air expelled from the tube, and it does not add to his comfort or well being to be tilted up.

The composition and amount of fluid given at a time has changed very much during the past few years. The old system of four ounces of egg and peptonised milk, every four hours, is passing away, and in its place we are giving much larger amounts at longer intervals. The patient can be kept on enemata of eight or ten ounces, with intervals from six or eight hours, for weeks. If it is only desirable to keep the patient on rectal feeding for a short time, the interval can be lessened to four hours, but they do not retain these frequent feeds so well.

Dr. Beddard's suggestions based on physiology for ideal enemata—given in his article in the Gazette of October 12th, 1901, have been tried, and with some modifications have been found successful. Patients have been fed on them and done well in some cases for weeks. The usual method has been to give two varieties of enemata alternating—of the two enemata, one usually consisting of egg and starch, the other of meat juice and arrowroot, as—

(1)	White of 3 eggs.	
	Salt	grs. xl.
	Starch	ʒii.
	Peptonised milk up to	ʒviii.
(2)	Arrowroot	ʒii.
	Salt	grs. xl.
	Meat juice up to	ʒviii.

These enemata need very careful preparation, or they will be so thick and lumpy that it is impossible to pass them through a catheter. The starch and the arrowroot are used raw, ʒii. of the powder being taken. It is mixed with a little water till it is quite smooth, the whites of the eggs are beaten up separately, and the whole when mixed together should be of the consistency of thick cream. The enema should be strained through butter muslin; if properly prepared the whole passes through the muslin, leaving no residue. The fluid should be heated by being placed in a vessel standing in a basin of hot water, and should be given at a temperature rather below than above blood heat.

In some cases it is desired to give stimulant, and ʒi. or more of brandy is added. This is quite satisfactory for a few feeds, but the spirit irritates the mucous membrane and cannot be continued long.

Where there is collapse and much thirst, saline injections can be given in addition to the enemata. The best way to judge of the amount needed is to allow the fluid to run in gently from a considerable height and to go on until it ceases to run. If any attempt is made to force the fluid in, the whole amount is usually returned. In severe collapse as much as two or three pints can be given in this way, and the injections can be repeated 4 hourly. Thirst is generally relieved by one or two pints in the twenty-four hours.

In Lighter Vein.

YE LAY OF YE ANCIENT CHARITIE.

I.

Then out spake brave Odgirius,
The Junior Charitie,
"Who's by my side, this Autumn tide,
To keep the breach with me?"
Then up sprang gallant Maherus,
Of Libyan blood was he,
"Lo! I'll sit tight, by day or by night,
And never trouble thee."

II.

Then out spake Barrius Nævus,
Of Iberian blood was he,
"A bag have I bought, which really ought
To satisfy even thee.
A craniotome, and a cephalotribe,
And forceps—vun, two, tree;
What should I dread? Face, breech or head,
Can be easily managed by me."

III.

Then loudly cried Benettus,
A squire from the West Countree,
"I rather suppose I can diagnose
A face from a L.O.P.
'First Lines' I've read, and Galabin,
And Dakin's Midwifrie,
Till October end, I never shall send,
Save perhaps for contracted P."

IV.

Then out spake proud Harveius,
Of Spartan blood was he,
"If it snows or it rains, I can use my brains,
And that sufficeth for me."
Then quickly cried Franklinius,
A deuce of a "blood" was he,
"When I'm in grief, I will send for relief,
If—it happens to be time for tea."

V.

And out spake staunch Mayburius
(And very hot stuff was he),
"If my right hand meet either Shoulder or Feet,
You can put your last dollar on me."
"Odgirius," quoth Benettus,
"We go forth—the Dauntless Six!
With ardour we're filling, but we'll always be willing
to help you out of a fix."

VI.

Then out spake the Chief Odgirius,
"You are all too hot for me:
If you start so strong, we shall all go wrong,
In this Ancient Charitie.
If it snows or it rains, *don't* use your brains,
It 's a fatal thing for ye;
All will be right, if you'll just sit tight,
And quickly send for me." GLAUCOPIS.

Guy's Hospital Medical School.

(UNIVERSITY OF LONDON.)—PRACTICAL BACTERIOLOGY.

A practical class in Clinical Bacteriology will be held in the Bacteriological Department during the months of November and December, 1903.

An advanced course in Bacteriology, adapted to the requirements of the M.D. (State Medicine) and the various Public Health diplomas will be held from January to March, 1904.

For further particulars apply to the Dean, Guy's Hospital, S.E.

Guy's Hospital Pupils' Physical Society.

Winter Session, 1903–1904. 8 to 9.30 p.m.

1903.

Oct. 10.—Opening Meeting. Subject: "Pitfalls." J. F. Goodhart, M.D., LL.D. Sir Samuel Wilks, Bart., M.D., LL.D., F.R.S., in the Chair.

24.—Clinical Meeting. President: C. H. Robertson.

Nov. 7.—"The use and limitation of blood counting." G. Russell. President: P. R. Bolus.

21.—Pathological Meeting. President: H. F. B. Walker.

Dec. 5.—"The relation of Dental Caries to Disease." K. Black. President: F. W. Morton Palmer.

19.—Debate. "Medical Education." President: P. N. Blake Odgers.

1904.

Jan. 16.—Clinical Meeting. President: K. Black.

30.—"The present System of Treating Fractures." P. A. Peall. President: G. A. Ticehurst.

Feb. 13.—Pathological Meeting. President: G. Evans.

27.—"The Diagnosis and Treatment of Coma." N. I. Spriggs. President: E. H. B. Milsom.

Mar. 12.—Treasurer's Prize Essay on "The Uses of Electricity and Light in Surgery." President: W. M. Mollison.

N.B.—On the Pathological and Clinical Evenings the Society will meet in the Hospital Library. On other Evenings the Society will meet in the Smoking Room of the Students' Club.

PAPERS FOR 1904–1905.

The Presidents invite Members who are willing to read papers before the Society, to communicate the titles of such papers, together with the names of the authors, to one of the Honorary Secretaries, on or before the 1st of September, 1904.

Pass List.

University of Durham.

DEGREE OF DOCTOR IN MEDICINE FOR PRACTITIONERS OF FIFTEEN YEARS' STANDING.

G. T. Hugill.

DEGREE OF BACHELOR IN MEDICINE.

J. G. O. H. Lane, A. Reid.

DEGREE OF BACHELOR IN SURGERY.

J. G. O. H. Lane.

THIRD EXAMINATION FOR THE DEGREE OF BACHELOR IN MEDICINE.

B. W. Lacey.

FIRST EXAMINATION FOR THE DEGREE OF BACHELOR IN MEDICINE.

CHEMISTRY AND PHYSICS.—L. K. Edmeades, T. H. V. King, J. F. Young.

ANATOMY AND BIOLOGY.—H. C. W. Allott, E. P. H. Joynt, H. F. Joynt.

Appointments.

NAVAL.

Staff-Surgeon NORMAN L. RICHARDS, R.N., has been appointed to the *Psyche*.

WARLOW, FRANK, L.D.S. Eng., has been appointed Dental Surgeon to the Royal Naval College, Osborne.

Rev. L. B. SLADEN, late Acting Chaplain to Guy's Hospital, has been appointed by the Trustees to the Vicarage of Selby Oak, in the Diocese of Worcester.

Change of Address.

Dr. Kenneth Anderson has removed from Weston-super-Mare to Evesleigh, Banwell, Somerset.

Dr. Herbert Cardin, from Tierney Road, Streatham, S.W., to Stock, Ingatestone, Essex.

Mr. Kenneth Goadby, from the Mall, Wanstead, and Duchess Street, W., to 21, New Cavendish Street, Cavendish Square, W.

R. H. Jocelyn Swan, M.S., F.R.C.S., from St. Thomas' Street, S.E., to St. Peter's Hospital, Henrietta Street, Covent Garden, W.C.

Dr E. W. Ainley Walker, from 40, Devonshire Street, W., to University College, Oxford.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Obituary.

George Frederick Humphreys.

The sad news of the death of George Frederick Humphreys, who died in hospital at Poona, India, at the age of twenty-four, has caused deep and widespread regret throughout the hospital, where he was so lately at work and so well esteemed by all.

In May last, two months after landing in India, the symptoms of kidney disease developed, uræmia supervening; he was practically recovered two months later, but symptoms returned at times, and he died after a week's illness from uræmia on September 26th, 1903.

The son of a Guy's man, F. W. Humphreys, Esq., F.R.C.S., he was educated at St. Paul's School, and from there came to Guy's in 1897. He passed through the dissecting-room, taking the M.R.C.S. course, and entered the wards in 1899, where he soon established a reputation as a sound and eminently practical man, always as he passed from one "firm" to another, highly praised by his contemporaries, as a fellow-worker to be relied upon on all occasions, and no less esteemed as a good companion. He was fond of sports, keen on rowing and Rugby football, figuring at times in one or other of the fifteens, and always thoroughly patriotic towards Guy's in work and play—no more enthusiastic supporter than he ever attended a Hospital Cup-tie, were it Rugby, Association, or cricket.

He qualified in April, 1902, and, without applying for any senior appointments, passed straight into the Indian Medical Service, where all who knew him felt assured he would succeed. Only leaving England in the spring of this year, he leaves many personal friends still at Guy's to mourn his early death. His is another name added to the list of young Guy's men, cut off within so short a time of leaving, just as they are starting in a new field, with every prospect of success, and while their memory is fresh in the minds of many still at Guy's.

Chapel News.

The ordinary Services in the Chapel are as follows;—

Sundays.—Holy Communion at 7 and 8.45 a.m. Matins and Sermon, 11 a.m. Evensong and Sermon, 7 p.m.

Saints' Days.—Holy Communion at 7 and 8.45 a.m.

Thursdays.—Holy Communion at 7 a.m.

Evensong is said daily in the Chapel at 5 p.m.

The Harvest Festival Services will be held next Sunday, October 11th. The preacher in the morning will be the Rev. L. N. Woolley, of St. Jude, Peckham; and in the evening the Rev. C. O. Pickard-Cambridge, of St. Paul, Lorrimore Square.

The Collections throughout the day will be for Foreign Missions.

From the Gazette's Special Pathologist.

All specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. Wells.

NOTICES.

H. A. L., Swansea.—No tubercle bacilli were detected in this sputum, which in character was non-purulent and contained a large amount of mucus.

H. L., Manchester.—Specially prepared and stained specimens of the deposit of this urine showed the presence of a few tubercle bacilli.

T. R. A., Chadwell Heath.—Reaction alkaline, sp. gr. 1011; albumen, very small amount; sugar, absent; blood, *vide* infra. Microscopical examination of the centrifugalised deposit.—The deposit is considerable in amount and contains a fair number of triple phosphate crystals, with a distinct excess of leucocytes and squamous cells and a few scattered red blood discs; bacteria also are extremely numerous. No tube casts nor renal cells can be found, and tubercle bacilli are not present in suitable preparations. The condition is suggestive of bacteriuria with alkaline decomposition of the urine, giving rise to a considerable amount of vesical catarrh.

H. T. H., Heytesbury.—This sputum contained a very large number of tubercle bacilli.

PATHOLOGIST.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Sport.

The following are this season's fixtures:—

RUGBY FOOTBALL.

First Fifteen.

1903.			
Oct.	3	Trial game	Home
	10	Lennox	Home
	17	Catford Bridge	Away
	21	Cambridge University	Away
	24	Rosslyn Park	Home
	31	Kensington	Home
Nov.	14	Streatham	Home
	21	Old Merchant Taylors	Away
	28	London Irish	Away
Dec.	5	Northampton	Away
	19	Richmond	Away
1904.			
Jan.	2	Old Leysians	Home
	9	Catford Bridge	Home
	16	Rosslyn Park	Away
	23	London Welsh	Away
	30	R.I.E.C.	Home
Feb.	3	Oxford University	Away
	6	Kensington	Away
	13	Lennox	Away
	20	Harlequins	Home
	27	Marlboro' Nomads	Home

Second Fifteen.

Oct.	10	Lennox II.	Away
	17	Catford Bridge II.	Home
	21	Boro' Road College	Home
	24	Surbiton "A"	Away
	31	Kensington II.	Away
Nov.	7	Rosslyn Park II.	Away
	11	Bart.'s "A"	Home
	14	Old Dunstonians	Away
	21	Rosslyn Park II.	Home
	28	Civil Service II.	Away
Dec.	5	Old Millhillians	Home
	9	St. Thomas's "A"	Away
	12	Kingston	Away
	19	Old Merchant Taylors II.	Home
1904.			
Jan.	9	Catford Bridge II.	Away
	16	Surbiton "A"	Home
	23	Norwood	Away
Feb.	3	Bart.'s "A"	Away
	6	Kensington II.	Home
	10	St. Thomas's "A"	Home
	13	Lennox II.	Home
	24	Boro' Road College	Away
	27	Old Merchant Taylors II.	Away
Mar.	5	Wasps II.	Away

Third Fifteen.

Oct.	14	King's College, Eng. II.	Away
	17	Park House "B"	Away
	24	Old Alleynians III.	Away
	28	Dulwich College II.	Away
	31	Lennox III.	Away
Nov.	7	Kensington III.	Away
	14	Royal School Mines II.	Away
	18	Blackheath School	Away
	21	Ealing "A"	Away
	25	Royal School Mines	Away
	28	Wasps III.	Away
Dec.	2	Tonbridge School II.	Away
	5	Old Blackheathens	Away
	8	Epsom College	Away
1904.			
Jan.	9	Ealing "A"	Away
	16	Old Blackheathens	Away
	23	Catford Bridge III.	Away
	27	King's College, Eng. II.	Away
	30	Blackheath School	Away
Feb.	6	Wasps III.	Away
	10	Dulwich College II.	Away
	13	Lennox III.	Away
	20	Catford Bridge III.	Away
	27	Old Alleynians III.	Away
Mar.	12	Park House "B"	Away

ASSOCIATION FOOTBALL.

First Eleven.

1903.			
Oct.	3	Trial game	Home
	7	Trial game	Home
	10	Surbiton Hill	Home
	14	R.M.A.	Away
	17	Normanhurst Druids	Home
	24	Clapham Rovers	Home
	28	Hastings	Away
	31	R.I.E.C.	Home
Nov.	7	Reigate Priory	Away
	14	Old Westminsters	Home
	18	Emeriti	Home
	21	Beckenham	Away
	28	Old Cranleighans	Home
Dec.	2	Old Carthusians	Home
	5	Tunbridge Wells	Away
	9	Wellingborough Masters	Away
	12	Kenley	Home
	16	Sanatorium	Away
	19	South Eastern College	Home
1904.			
Jan.	9	Old Reptonians	Home
	16	Beckenham	Home
	23	Reigate Priory	Away
	30	West Kent	Away

Feb.	6	Ewell	Away
	10	R.I.E.C.	Away
	13	Emeriti	Away
	20	Kenley	Away
	27	Old Foresters	Home
Mar.	5	Surbiton Hill	Away
	12	Normanhurst Druids	Away
	19	Old Harrovians	Home
	26	Clapham Rovers	Away

SECOND ELEVEN.

Oct.	17	Normanhurst Druids	Away
	24	Clapham Rovers	Away
	31	Woodford Albion	Home
Nov.	7	Cheshunt 2nd XI.	Home
	14	Carshalton Park	Away
	21	Beckenham 2nd XI.	Home
	25	Leavesden Asylum	Away
Dec.	2	Sevenoaks School	Away
	5	Alleyn 2nd XI.	Home
	12	Surbiton Hill 2nd XI.	Away
	19	Emeriti 2nd XI.	Away
1904.			
Jan.	9	Cheshunt 2nd XI.	Away
	16	Beckenham 2nd XI.	Away
	23	Carshalton Park	Home
	30	Central Technical College	Home
Feb.	6	Ewell 2nd XI.	Home
	13	Surbition Hill 2nd XI.	Home
	20	Clapham Rovers 2nd XI.	Home
	27	Woodford Albion	Away
Mar.	5	Old Cranleighans 2nd XI.	Home
	12	Alleyn 2nd XI.	Away
	19	Central Technical College	Away

The Cross Country Club.

This club, besides being a constituent institution of the Clubs' Union, is also merged in the United Hospitals' Hare and Hounds, of which the officers are as follows:—President: Percy Furnival, Esq., F.R.C.S. Vice-Presidents: L. A. Dunn, Esq., F.R.C.S., C. H. Fagge, Esq., F.R.C.S., H. Morley Fletcher, Esq., M.B., and H. B. Robinson, Esq., M.S. Captain: P. Goss (Bart's.). Hon. Secretary and Treasurer: O. S. Norton (Guy's); and a Committee of Six from the Hospitals subscribing to this club, viz., St. Bart's., St. Thomas's, Guy's, and London.

By the kindness of the Blackheath Harriers, United Hospitals' men run with that club and have the privilege of using the excellent headquarters of the senior club, besides enjoying the services of their trainer. Cross Country runs take place from their headquarters at the Green Man, Blackheath, on Saturdays at 3.30 p.m., in addition to which short training runs are held on Wednesday evenings at 7.45 which are a great help to keeping fit.

The fixture list of the U.H.H. & H. includes matches against Oxford, Cambridge and Dublin Universities, the Blackheath Harriers, South London Harriers, Ranelagh Harriers, Thames Hare and Hounds, Lancing College and Wellington College, and at least one handicap is held during the season.

As regards Inter-Hospital contests, Dr. W. Kent Hughes, in 1887, presented a Challenge Cup for competition among the London hospitals, since which date Guy's, who "walked over" last season have held the trophy on ten occasions.

Paby Gymnasium.

A General Meeting will be held in the Gymnasium on Tuesday, (13th) at 4.30 p.m.

Business:

The commencement of classes;

And to consider the advisability of having massage classes in the Gymnasium.

Birth.

EYRE.—On September 30th, at Wandle House, Wandsworth Common, to Dr. and Mrs. Eyre, a son.

MALCOLM.—On October 6th, at 13, Portman Street, W., the wife of John D. Malcolm, F.R.C.S. Edin., of a son.

ROUTH.—On September 26th, at Denholme, Blackheath Park, S.E., the wife of Charles F. Routh, M.D., of Southsea, prematurely of a son, who survived his birth only a few hours.

Marriages.

LE FEUVRE—WESTERTON.—On September 8th, at St. John's, Bulawayo, by the Venerable Archdeacon Beavan, William Philip Le Feuvre, M.R.C.S., L.R.C.P. Lond., Railway Medical Officer, to Florence Westerton, second daughter of Charles E. Westerton, of Rondebosch, Cape Colony.

HARDENBERG—WEALL.—On September 24th, at St. Andrew's Church, Watford, by the Rev. Canon Reith, Vicar, assisted by the Rev. O. Cockrem, LL.D., and the Rev. R. J. Glenn, Edward Francis Herman Hardenberg, M.B., L.R.C.P., M.R.C.S., of Duffield House, Watford, to Annie Margaret Graham (Daisy), second daughter of John Weall, of Rutland Lodge, Watford.

Deaths.

HUMPHREYS.—On September 26th, at Poona, India, George Frederick Humphreys, Lieutenant, I.M.S., only son of F. W. Humphreys, F.R.C.S., in his 24th year.

IMAGE.—On September 26th, at Herringswell House, Mildenhall, Suffolk, William Edmund Image, D.L., J.P., F.R.C.S., in his 97th year.

ED.—J. M. B.

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Calendar of Coming Events.

October, 1903.

Sat. 24.—Messrs. Golding-Bird and Dunn's take-in; Drs. J. Cook and A. M. Roome; Cl., P. A. Peall.
1 p.m., Clinical lecture by Dr. Hale White.
G.H.R.F.C., I., v. Rosslyn Park, home.
II., v. Surbiton A, away.
III., v. Old Alleynians III., away.
G.H.A.F.C., I., v. Clapham Rovers, home.
II., v. Clapham Rovers II., away.
G.H.P.P.S., Clinical Meeting. President, C. H. Robertson.

Mon. 26.—1.15 p.m., Clinical lecture by Sir Cooper Perry. Final M.B. Lond. Exam. begins.

Tues. 27.—1.15 p.m., Clinical lecture by Mr. Lucas.

Wed. 28.—G.H.R.F.C., III., v. Dulwich College II., away.
G.H.A.F.C., I., v. Hastings, away.

Thur. 29.—Messrs. Jacobson and Sir Alfred Fripp's take-in; Drs., E. C. Hughes and E. W. Sheaf; Cl., F. H. Wallace.

Sat. 31.—1 p.m., Clinical lecture by Dr. Hale White.
G.H.R.F.C., I., v. Kensington, home.
II., v. Kensington II., away.
III., v. Lennox III., away.
G.H.A.F.C., I., v. R.I.E.C., home.
II., v. Woodford Albion, home.

November.

Mon. 2.—1.15 p.m., Clinical lecture by Mr. Targett.
Last day for applying to Registrar for Form of Entry for M.D. and M.S. Lond.

Tues. 3.—1.15 p.m., Clinical lecture by Mr. Lucas.
Last day for applying to Registrar for Form of Entry for B.S. Lond.

Thur. 5.—G.H.C.U., Address by the Right Rev. Bishop Taylor-Smith.
Probable date of Primary Fellowship Exam.

Fri. 6.—Probable date of 1st Professional and Final L.D.S. Eng. Exams.

Sat. 7.—1 p.m., Clinical lecture by Dr. Hale White.
G.H.P.P.S., "The Use and Limitation of Blood Counting," by Mr. G. Russell.
G.H.R.F.C., II., v. Rosslyn Park II., away.
III., v. Kensington III., away.
G.H.A.F.C., I., v. Reigate Priory, away.
II., v. Cheshunt II., home.

Guy's Hospital Gazette,

OCTOBER 24, 1903.

Chronic Pancreatitis.

CLINICAL LECTURE BY Dr. W. HALE WHITE.
October 3rd 1903.

Gentlemen,—Some of you may have been round Mary ward and seen the woman in No. 13 bed. If you have, you will remember that she has had jaundice for a long while. I pointed out that frequently in the wards—and it will be so afterwards in practice—you are presented with this difficulty; that you are face to face with a patient who has had long-standing jaundice, who has a large liver, but who has no heart disease to cause a nutmeg liver. And the problem presents itself to you, What can be the matter with a patient presenting these symptoms? It is a very common problem. And the causes of such a condition, as we pointed out at the bedside, are, cirrhosis of the liver, malignant disease of the liver, and obstruction to the common bile duct; and this latter may be caused either by an impacted gall-stone, or carcinoma of the head of the pancreas, or chronic pancreatitis. Now, in the particular woman whose case I have alluded to there were many reasons for thinking that she had cirrhosis. For example, she gave a history of hæmatemesis; she looked like a drinker; the feel of the liver was that of a cirrhotic liver; you will remember she was almost paraplegic, and her knee-jerks were difficult to elicit. These two last symptoms pointed to some peripheral neuritis. So we concluded that probably she had got cirrhosis of the liver. She has only just come in, and I have only seen her once, and I do not know

yet whether that diagnosis has been confirmed, because, as you know, she is no longer under my care. But in thinking of a subject for the lecture to-day, it struck me that probably of all those causes I gave you just now of long-standing jaundice you have less practical acquaintance with the last one, namely, chronic pancreatitis, than with the others; and therefore I thought it might not be unprofitable if we talked it over to-day.

Now, the first thing we have to bear in mind is, that this disease—chronic pancreatitis—has no relation to acute hæmorrhagic pancreatitis, which those of you at any rate who are clinical assistants always have in mind, because of the fact that it is often mistaken for a perforating gastric ulcer, or intestinal obstruction, and the patient is usually quickly dead, within a few hours, or at most a few days. But the disease that I want to talk to you about to-day, chronic pancreatitis, has nothing whatever to do with acute hæmorrhagic pancreatitis.

Naturally, the first thing you will ask me is, What does the pancreas look like in this disease which you are describing? Well, the gland is enlarged, and it is hard; and inasmuch as the head of the gland is the largest part of the organ, the enlargement shows most there; so that when the *post-mortem* is made, or when, as more frequently happens, the disease is discovered at an operation, it is found that the head of the pancreas is much enlarged and hard. Sometimes there is a little chronic peritonitis over it, but that probably is unimportant: the main thing is a chronic enlargement and induration of the pancreas. The next thing it would be natural to ask is, What are the causes of this condition? The hard pancreas may be caused by backward venous pressure, if you are going to apply the word pancreatitis to a condition of the pancreas comparable to the hard nutmeg liver which you get when there is backward pressure in heart disease, or the tough indurated kidneys which you also get in heart disease. Should you agree to apply the word pancreatitis to this condition, it is undoubtedly the commonest cause of pancreatitis. I looked through our *post-mortem* records here, and found that in 26 instances out of 6,700 autopsies the pancreas has seemed to the demonstrator of morbid anatomy sufficiently hard for him to record the fact when writing up the account of the case. Out of those twenty-six, in twenty-three there was sufficient disease to explain the backward pressure. In many of them the liver was nutmeg also, the kidneys were indurated, and the patient usually had severe heart disease. In two of the cases that I found in our records the condition was associated with cirrhosis of the liver; and it is tempting to assume, that owing to the difficulty of portal circulation in cirrhosis of the liver, the induration of the pancreas was due to backward pressure in the portal area. But when you think of that explanation you must also remember that many people consider that over-indulgence in alcohol will cause a hard indurated pancreas, as it causes an indurated nutmeg liver. So we must leave the question open at present as to whether the hard pancreas was due in these two cases to cirrhosis of the liver, or due to the alcoholic excess independently of cirrhosis of the liver.

Then the next causes for chronic pancreatitis are those that may be grouped together under the heading of obstruction to the pancreatic duct. There is no doubt that that leads to a chronic inflammatory induration of the pancreas with an excess of fibrous tissue in the gland. The common causes of obstruction of the duct are, of course, a biliary calculus; for you will remember from your anatomy that the pancreatic duct and the hepatic duct pass into the duodenum together, and that the smallest place which a gall-stone has to pass is just at the entrance into the duodenum. The gall-stone may get impacted in the wall of the duodenum and so block both the common bile duct and the pancreatic duct, and that will lead to a hard induration of the pancreas. Another cause of obstruction is a malignant growth pressing on the pancreatic duct. And another—a very rare but nevertheless extremely interesting cause—is a pancreatic calculus itself impacted in the duct. The production of pancreatitis from obstruction to the duct is easy to understand. Then, authors who are interested in this subject group together as a third cause of pancreatitis any spread of inflammation up the

duct from the duodenum—a duodenal catarrh in fact. Here we are in the same difficulty as we are in regard to catarrhal jaundice. Catarrh is difficult to deny and difficult to prove in many cases, because by the time the patient dies, the catarrhal inflammation of the duodenum, which had spread up the pancreatic duct and set up chronic pancreatitis, will have passed off. All you can say is, that it is very difficult to demonstrate in any particular case. Then, quite recently it has been shown that chronic pancreatitis may occur in typhoid fever. There really is, I think, hardly any part of the body in which chronic inflammation may not occur as the result of typhoid fever.

Another group of causes of pancreatitis which have been set down are those in which it is said that the condition is due to degenerate endarteritis and the vessels of elderly people, but naturally you do not detect pancreatic vascular disease during life, but post-mortem only. And it would be a very good subject for any of you to take for a thesis; to cut systematically the pancreas in a number of old people, and see whether those who maintain that there are chronic inflammatory fibrous changes of the pancreas when the vessels are degenerate, are correct. Then it is said that syphilis will cause chronic inflammation of the pancreas, but this is almost always the result of congenital syphilis and does not interest us now, because it is found that children having it die shortly after birth.

It has also been said that tubercle will cause chronic pancreatitis, that we know very little about. And some of you might like to extend the term chronic pancreatitis to the atrophied gland that you meet with so frequently in diabetes. I am constantly pointing out to you in the wards that the pancreas, in many severe cases of diabetes, is obviously diseased; it is small and atrophic in, roughly speaking, one-third of all the fatal cases of diabetes.

Those, I think, comprehend all the described varieties of chronic pancreatitis, and you may say that it is of very little clinical interest, but I hope to show you before I have done that it is not so. Of course you may argue in this way: that the chronic induration of the gland which is associated with backward pressure in heart disease, is only part of a general condition and so has very little special interest. Again, the obstruction of the duct is either due to a gall-stone, in which case it will be of interest from the gall-stone point of view, or else it is due to a growth, in which case the interest of the growth will overshadow the following pancreatitis. Or it is due to pancreatic calculus, which is so rare that I think we have only had three cases here in about thirty years. But the interest is really much more than you would expect, for this reason. Many cases of disease of the liver have of late years been operated upon, especially when the patient has been deeply jaundiced, in the hope that the gall-bladder might be drained and so the jaundice might be relieved. This has been done as a palliative measure even in malignant disease, where the pressure of enlarged malignant glands on the common duct has led to deep jaundice. Surgeons, I say, have done this many times of late years, and the surgeon, after he has drained the gall-bladder, has often been surprised to find that the patient has recovered and got quite well. And he then calls to mind the fact that at the operation the head of the pancreas was felt to be enlarged and hard; and the case is set down, I believe rightly, to chronic pancreatitis, and the patient has got well because the chronic inflammation of the pancreas has subsided. And another group of cases has come before us, of great clinical interest, namely, those in which surgeons, having diagnosed that the patient was suffering from gall-stone in his common duct, have operated with the view of removing the gall-stone, and have found the head of the pancreas enlarged and hard. When that was first noticed the surgeon who discovered it said at once, "It is a hopeless case; the patient has carcinoma of the head of his pancreas, as well as gall-stone." The gall-bladder was drained and the abdomen closed, but the patient got well. So you see it is a matter of very great interest. The larger number of cases of chronic pancreatitis have been thought, before operation, to be malignant disease of the liver or pancreas, and have not been thought to belong to the second group which I mentioned

just now, namely, impacted gall-stones. You see the result of this was, that the teaching got abroad—and quite naturally—that it was necessary for the cure of these cases of chronic pancreatitis that the gall-bladder should be drained.

I will now relate to you a case which, to my mind, shows that that is not always necessary. The case is this: The patient was a man æt. 62, who I saw as long ago as July, 1901. I have often thought of giving a lecture upon him, but I have not used the case because I wanted time to elapse so that I might give you the after-history. He was a patient of two old Guy's men—Dr. James Andrews and Dr. Collingwood Andrews. I saw him on July 2nd, 1901, with his two doctors, and we found him deeply jaundiced. He looked very ill, and he was not strong enough to sit up. He told us that a year ago he began to have pain over the region of the stomach, and that he had had it on and off ever since. It came on in paroxysms about seven or ten days apart, and lately it had been very severe. For the last six months he had been jaundiced, the depth of the jaundice varying from time to time. He had had no rigors, no rises of temperature, and he has hardly ever been sick during the illness. He was very emaciated, and had lost two stone in weight. We made a careful examination, including the rectum, and found absolutely nothing abnormal, but we thought that he was especially tender over the head of the pancreas. We all expressed the opinion that the patient was suffering from carcinoma of the head of the pancreas. The patient and his wife, and other friends, asked whether any operation could be done. We all three severely discouraged any operation; but, fortunately for our learning something about this disease, an operation was practically commanded, because the line taken by the friends was, that you say it is perfectly hopeless, and it is quite possible the surgeon might be able to do something; let him try. So accordingly Mr. Edmund Owen saw the patient, and a week after I saw him, Mr. Owen opened the abdomen. He put his hand in, and found the head of the pancreas so large and hard that he considered it proved that the patient was suffering from malignant disease of the head of the pancreas. He accordingly at once sewed up the wound and the patient was put back to bed. The bile passages were not touched, nor drained in any part. Four or five days after the operation the patient began to improve in health; his pain commenced to diminish, and his jaundice to disappear. From this time he began to put on flesh. I next saw him on August 16th, 1901, which was one and a half months after the operation. He then looked quite well, was not jaundiced, and had gained much flesh. I thought I could still feel something in the region of the head of the pancreas. I saw him next on September 16th, when he had gone back to his work. He weighed twelve stone one pound, and looked in excellent health. Nothing abnormal could be felt in the abdomen; the urine contained neither albumen, bile, sugar, nor diacetic acid. I wrote to him in June, 1903, and he reported that he was as well as usual, and had been so since I last saw him a year before, and he would be 65 years old in September.

Now, those who have been at work some time, have probably all met with cases of jaundice which did not appear to be, at the time at any rate, cases of gall-stones, and which were recorded as malignant disease, and given up as hopeless by the doctor, but which as time slowly went on, got well without any operation. If you will talk to any doctor of large experience you will find, I should think, that every one can give you accounts of cases which he has thought to be malignant disease of the liver, cases of deep jaundice, wasting, and so forth, but which have nevertheless got well. It is, of course, of no use to definitely record such cases as cases of chronic pancreatitis, because they may have been instances of a gall-stone which has been impacted, but which has subsequently passed and so the patient has got well. But you will have noticed in the case I referred to just now that the abdomen was opened, Mr. Owen's hand was passed into it, and no gall-stone was detected. But some of these cases that every doctor knows of, which had jaundice and were doomed as malignant disease of the liver or pancreas but

nevertheless get well, may at least have been cases of chronic pancreatitis. And I have notes of a case bearing upon that. A man, æt. 60, was seen by Dr. Warner Lacey. He had a slight attack of jaundice fifteen years ago, without much pain. It lasted fourteen days, and probably, from his account, it was catarrhal jaundice. For three months he has had jaundice and pain over the liver, which is not paroxysmal, like that of gall-stones. He has lost much flesh, has got weaker, his jaundice has varied in depth from time to time, but it has never been very deep. His liver is much enlarged, but no lumps can be felt on it. There is no evidence of any primary growth anywhere. These notes were made in November, 1902. Through the kindness of Dr. Lacey, I have heard about the patient recently. I learned that he remained much the same for some time, then gradually got better, and his jaundice slowly disappeared, so that it finished about six months after we saw him. I wrote to the patient the other day when I decided to give this lecture; he replied, and I gather from his letter that he is perfectly well.

So that, you see, is the account of a case such as I have indicated to you, a case which looked very like one of malignant disease of the liver. There was no indication whatever that it was a case of gall-stones, the patient slowly recovered, is now quite well, and was, I would suggest, suffering from chronic pancreatitis.

As these cases appear to show that chronic pancreatitis may get well if it is left alone, the second point to be considered is whether it is often fatal. Now, if fatal, it is, unless successfully diagnosed, almost certain to be regarded as malignant disease, either of the pancreas or of the liver, the reasons being the long-standing jaundice and the wasting. So it struck me that we could get some answer to the question by looking through our post-mortem records, and I took the last forty-one years and read through all the cases of malignant disease of the pancreas. There were fifty-seven cases in which there were secondary deposits elsewhere in the body. Obviously they could not be instances of chronic pancreatitis. But there were ten cases entered as malignant disease of the pancreas, in which there were no secondary deposits elsewhere, so it might be that the enlargement of the gland was really not due to malignant disease but to chronic pancreatitis, and that that was the reason why there were no secondary deposits, and yet the disease killed. And so I looked very carefully at the clinical notes of each of these ten cases. Of them, we can put aside four at once because microscopical sections were cut and the histologist was convinced that they were cases of malignant disease of the head of the pancreas. That leaves us six. Of these six, one was a fungoid growth, that could hardly have been a case of chronic pancreatitis. Another was a suppurating growth, and that could hardly have been a chronic pancreatitis. So you see we are narrowed down to four cases in forty-one years, which may possibly have been instances of chronic pancreatitis. One of those four, I think, was undoubtedly a fatal instance of this disease. It was under Dr. Frederick Taylor, and, with his permission, I give you the details of it.

A. A. W., a male, æt. 42, a travelling accountant, was sent to the hospital by Dr. Bisshopp, of Tunbridge Wells, on account of jaundice. He was admitted under Dr. Frederick Taylor on April 4th, 1892. No evidence of alcohol or syphilis. He first noticed jaundice with itching in May, 1891. Soon his motions became quite white. He had not then wasted. On admission he was deeply jaundiced and suffered much from itching. His liver was uniformly enlarged extending to three inches below the ribs. There was no pain. The urine was loaded with bile but otherwise healthy. The motions were very white. On May 2nd he complained of pain over the liver. By May 12th he had lost seven pounds. On May 16th there is a note saying he had diarrhœa, the motions were dark—evidently some bile was passing the obstruction. On May 23rd the motions were white again. By May 31st he had lost six more pounds; the sickness continued, he had abdominal pain, he became weaker and died. Here is a man who had jaundice for a long while, who had wasted, who had pain in the abdomen and who died. At the autopsy the body

was deeply jaundiced, the head of the pancreas was hard and much enlarged, and the pancreatic ducts and bile ducts were much dilated. The gall-bladder was normal. There were no gall-stones or secondary deposits anywhere in the body. Histologically, the pancreas showed an increase of embryonic connective tissue. The adjacent lymphatic gland was also examined and found to be healthy. You could not want a better case than that. There you see what is, I think, an instance of a patient who had a disease evidently indistinguishable during life from malignant disease of the pancreas; he had the wasting and the deep jaundice and he died. He certainly was suffering from a different condition from malignant disease of the pancreas, namely, chronic pancreatitis. But now you see only three cases are left out of ten, and in regard to those three it is impossible to decide whether they were malignant disease or not. I do not think all three can have been instances of chronic pancreatitis. So the evidence drawn from our very large *post-mortem* experience is that after forty-one years, which represents nearly twenty thousand *post-mortems*, we have only had one certain fatal case of chronic pancreatitis, and the largest number, which by any stretch we can be said to have had, is four, while possibly it is only one. So I think I have been able to show you, from the evidence of our *post-mortem* work here, that chronic pancreatitis is very rarely fatal. And also I think the two previous cases I have read to you, especially the one Mr. Owen operated upon, have shown that if the disease is left to itself it tends to get well.

Now, if I am right in my contention that chronic pancreatitis is rarely fatal and will usually get well if left alone, the conclusion you see, is very important, for some would have taught that in any patient with long-standing jaundice and loss of flesh, unless it was quite obvious that the patient was suffering from malignant disease, the gall-bladder should be drained. And the way it would be obvious would be by detecting a primary seat, say in the rectum or breast, or by feeling large nodules on the liver; or, again, by your detecting secondary deposits elsewhere. I say many would teach that unless it was clear that the patient was suffering from malignant disease, it is your duty to open the abdomen and see whether the case may possibly not be one of chronic pancreatitis; the reason being, of course, that those who would take that view would say that the patient will not get well unless the gall-bladder is drained. But I have been able to bring forward evidence quite contrary to you to-day; and it is clear that if the case is one of growth an operation is certainly unnecessary and undesirable. And if I am correct in my contention that if it is chronic pancreatitis, the disease is very rarely fatal, exploratory operation is not desirable. So you see we are narrowed down to this: that the only cases in which an exploratory operation is needed are those in which it is undoubtedly an impacted stone in the wall of the duodenum, blocking the pancreatic duct.

Now, you will say, surely these cases do so well by taking away the stone that unless the evidence of malignant disease is very strong it is nevertheless your duty to explore in case there may be a stone. But my experience has been that these cases of gall-stone, nearly always give some evidence of their being cases of gall-stones; either the patient gives you an undoubted history of gall-stones, or at the time you see him he has rigors and temperature, or some symptom or other pointing to the case being one of gall-stones. I can only tell you that my own experience has been that whenever the diagnosis has been in doubt as to whether the case has been one of impacted gall-stones, chronic pancreatitis, or malignant disease of the liver, and the abdomen has been opened to see which it is, it has never been a case of impacted gall-stones. In other words, we have always been able to diagnose gall-stones successfully, apart from an exploratory operation. I know perfectly well—friends have told me, and I have read of cases—that there are instances where it is not possible; but the only point I want to make here is, that at any rate an impacted gall-stone is generally recognised. So it comes to this: that if the patient is suffering from chronic pancreatitis, probably operation is unnecessary; and if from malignant growth, operation is certainly unnecessary; so it is only required when there

may be an impacted stone; and in such cases we generally diagnose the gall-stone before the abdomen is opened, and pancreatic calculi are so exceptional, that the stone is nearly always a gall-stone. Nearly always the exploratory operation shows the case is really one of growth. I could go on for a long while telling you of cases of jaundice, which had been explored in the hope that they were not growth, and yet they have turned out to be growth. Only the other day I saw a patient who was seen by several people, and at last, in desperation, the abdomen was explored. It was the usual tale, malignant disease; it was not chronic pancreatitis, it was not an impacted gall-stone.

Your last question might be a very pertinent one, namely: Can you, by any possibility, diagnose between a patient having this chronic pancreatitis, and one having malignant disease of the head of his pancreas, or of the liver, which the disease so closely resembles? I know of no distinctive points apart from the obvious ones that I have already mentioned, namely, finding the primary seat somewhere, large lumps on the liver, or finding secondary deposits elsewhere in the body. In both chronic pancreatitis and malignant disease of the head of the gland there is wasting and deep jaundice, in both the patient has clay-coloured stools, and in both cases, especially if the primary growth is in the head of the pancreas, the head of the gland is enlarged, and it is considerably enlarged in chronic pancreatitis, so that in both cases you may be able to feel a lump. I think I mentioned that in both cases you have local pain and tenderness. Then with regard to rare symptoms, they may occur equally in both cases. A very severe malignant disease of the pancreas, destroying all the gland, may lead to sugar in the urine. Very severe chronic pancreatitis, implicating the whole of the gland may lead to sugar in the urine. In both cases the stools may be occasionally fatty. In both cases, in quite exceptional instances, the vena cava gets pressed upon, or the portal vein may be thrombosed, or there may be ascites. So you see there is no point of distinction between the two. But again, the point I have tried to drive home is, that it does not very much matter, because it is no good exploring for malignant disease, and chronic pancreatitis will get well without.

Again, this disease, chronic pancreatitis, may be confounded not only with malignant disease of the gland, but it may also be confounded with malignant disease of the liver. That is obvious, because in so many patients with malignant disease of the liver you cannot feel the lumps, and the patients are wasted and deeply jaundiced. That it may be confounded with malignant disease of the duodenum needs no exposition. Again, it may clearly be confounded with malignant disease of the common duct, or with malignant disease in the glands in the portal fissure pressing on the common duct, and possibly with a tumour of the spine pressing on the duct, or indeed with anything which presses upon the duct.

The last point I would make is, that it is very probably much commoner than is supposed. If we were lecturing on gall-stones I could bring you many patients who give a history of gall-stones, who, at the time they were passing the gall-stones, became jaundiced, the jaundice lasting for some time, and then the patients wasted very considerably. They were, for some reason or other, in a part of the country where an operation could not be done, and a very unfavourable view is taken of their case. Slowly, however, they have got better, and the improvement has been so slow that it strongly suggests that with many people who have gall-stones the passage of the gall-stone sets up a chronic pancreatitis, which slowly gets better, and, to the surprise of the friends, the patient puts on flesh and gets well.

A Note on Radium.

Radium is prepared from a heavy black ore called Pitchblende, which exists, and is obtained by mining in, the Joachim Thal, in Bohemia. This ore yields Uranium, Polonium, and Radium.

The discovery of these two latter substances was made by Professor and Madame Curie, of Paris. In a lecture at the Royal Institute, reported in the *Times*, 20th June, 1903, the Professor enunciated the properties of Radium as follows:—

1. It is capable of spontaneously and continuously disengaging heat; this was proved by experiments in a liquid-air calorimeter. It maintains its temperature at a point three degrees higher than that of its surroundings,

without any apparent loss of bulk or physical alteration.

2. It rapidly affects photographic plates even through opaque bodies.

3. It produces luminous phenomena in barium platinocyanide and other phosphorescent bodies.

4. It renders air a conductor of electricity, thus discharging a charged electroscope.

5. It also gives off radio-active emanations, which are capable of being aspirated through an instrument resembling a gas tube, and are capable of rendering other bodies radio-active.

6. Its chemical action can produce sores on the skin and even induce paralysis.

Sir William Crookes (*Chemical News*, 22nd May, 1903) and Sir Oliver Lodge (*Nineteenth Century*, July, 1903) have classified the characteristic emanations of Radium into three groups which may be shortly described as :—

1. Of the same nature as the X-rays of Röntgen.

2. Electrons negatively charged, similar to cathode rays in a Crooke's tube and to the Lenard rays outside such a tube.

3. Rays, composed of positively charged atoms of matter, emitted at immensely high speed.

Sir Oliver Lodge further asks these two pregnant questions : Are these emanations gaseous? Does helium enter into their composition? In a lecture delivered at University College on 6th October, 1903, Sir William Ramsay referred to the researches of Mr. Soddy and himself, which proved that in part at least the emanations of Radium were gaseous ; that the gas was reducible to a liquid form if subjected to cold of the temperature of liquid air ; and that if left to itself for a month it changed into helium.

Helium exists largely in the sun and in very minute quantities in the atmospheric air.

As Oliver Lodge says, possibly we have here an example of transmutation of elements ; a theory which, if correct, will simply revolutionize science. Curie estimates that 1 gramme of Radium can supply 100 calories (units of heat) per hour (see communication by W. E. Wilson in *Nature*, 9th July, 1903).

A scrap of Radium in an opaque envelope, brought near to a diamond in the dark, causes it to glow brilliantly, whereas "paste" remains dull.

Medically—and here it is most necessary to be guarded n one's remarks—it is hoped that Radium Salts may possibly be found useful in the treatment of rodent ulcer and lupus ; in phthisis by virtue of its aspirated emanations and perhaps eventually in other diseases.

The preparation most used at present is the Bromide of Radium ; some claim that the Nitrate is more powerful. The two accompanying photographs are of interest ; in each case the photographic plate was wrapped in black paper, enclosed in a brown paper envelope, and thus exposed for twenty-four hours, in Fig. I with a safety-pin superimposed, to the action of five milligrammes of Radium Bromide in a glass tube ; in Fig. II to a fragment of the ore, pitchblende, with a circular perforated metal plate placed outside the envelope.

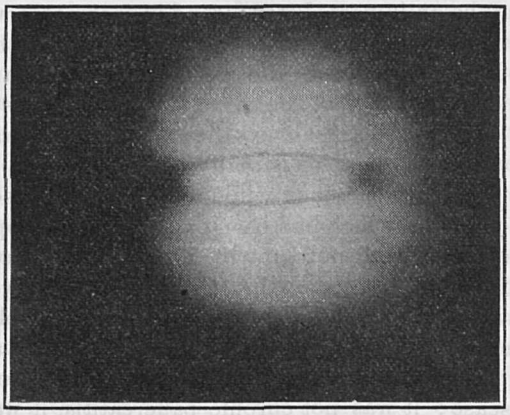

Fig. I.—Photo of Safety Pin taken by ·005 grms. of Radium Bromide through a brown and a black envelope. Exposure 24 hours.

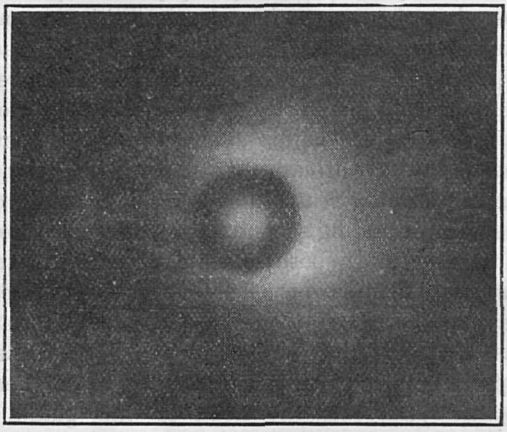

Fig. II.—Photo of Copper Washer taken by piece of Pitchblende. Exposure 24 hours.

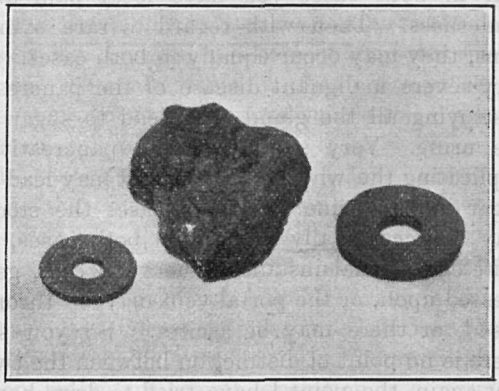

Fig. III.—Photo of piece of Pitchblende and Copper Washers.

This short note on Radium is written at the instigation and with the assistance of Dr. Bryant, who is in charge of the Electrical Department, and with the assistance of Mr. Sales-Barker.

The photographs were taken by Mrs. Toogood-Hill, the hospital artist.

G. SICHEL.

Surgery Extension Fund.

In publishing the second list of donations to the above Fund, we are glad to state that the plans for the Women and Children's Shelter have been prepared, and approved by the House Committee, and the work will be proceeded with forthwith.

The Shelter will be erected in the Quadrangle on the eastern side of the Colonnade.

It will be remembered that the amount originally asked for by the Surgery Sister was £500. Considerably more than this amount has now been subscribed, but to carry out the plans efficiently and completely it has been found that approximately £800 will be required. The Sister, therefore, renews her appeal to the extent of £110, which is the balance needed.

SECOND LIST OF CONTRIBUTIONS.

	£	s.	d.
Amount previously acknowledged	239	14	0
"A Friend"	150	0	0
"E. S." (a thank offering)	100	0	0
James Banks Stanhope, Esq.	50	0	0
Henry Willett, Esq.	50	0	0
Anonymous	20	0	0
Brien Cokayne, Esq.	10	0	0
"M. W. M."	10	0	0
Dr. P. H. Pye-Smith	5	5	0
Jeremiah Colman, Esq.	5	5	0
"L. M. M."	5	5	0
Lieut.-Col. John Ince, M.D.	5	5	0
Mr. and Mrs. Herbert Dimond	5	0	0
Philip de Clermont, Esq.	5	0	0
Mrs. Love	4	0	0
Chas. R. G. Hoare, Esq.	5	0	0
"C. R."	2	2	0
Miss Eileen Christmas	2	0	0
The Countess of Portsmouth	2	0	0
The Misses Smith	1	10	0
Mrs. Cornish	1	1	0
Col. H. J. Robinson	1	1	0
Carleton F. Tufnell, Esq.	1	1	0
"October Externs"	1	1	0
Mrs. Arthur Lanyon	1	1	0
Sir Edward L. O'Malley	1	0	0
Mrs. A. Basham	1	0	0
R. Knight Bruce, Esq.	1	0	0
G. T. S. Sichel, Esq., F.R.C.S.	1	0	0
Mrs. Tarratt	1	0	0
Smaller sums	1	16	0
	£690	7	0

Obituary.

William Job Maillard, M.D., V.C., R.N.

Staff-Surgeon William Job Maillard, V.C., M.D., R.N., whose sad death we have already reported, received his medical education at Guy's Hospital, where he was one of the most distinguished students of his year. He obtained the diplomas of M.R.C.S., L.R.C.P. in 1888, and in the same year graduated M.B. Lond.; three years later he graduated M.D. Lond., and obtained the number of marks qualifying for the Gold Medal. He entered the navy in August, 1889. He served on H.M.S. *Blake*, then flagship of the North America and West Indies station, and afterwards on the *Hazard* in the Mediterranean. It was while serving on this ship at Candia, on September 6th, 1898, he won the Victoria Cross under the circumstances officially related as follows:—"During the landing of seamen from H.M.S. *Hazard*, Surgeon Maillard, who had disembarked and reached a place of safety, returned through a perfect deluge of bullets to the boat, and endeavoured to bring into safety Arthur Stroud, ordinary seaman, who had fallen back wounded into the boat as the other men jumped ashore. Surgeon Maillard failed to bring Stroud in, only through the boat being adrift, and it being beyond his strength to lift the man (who was almost dead) out of so unstable a platform. Surgeon Maillard returned to his post with his clothes riddled with bullets, though he himself was unhurt." He was specially promoted Staff-Surgeon on June 2nd, 1899, for distinguished services, and the decoration V.C. was personally conferred upon him by Her late Majesty Queen Victoria. Very shortly after this, signs of mental disorder began unmistakably to manifest themselves, and throughout his long and painful illness, which those about him knew could have but one result, he was devotedly nursed by his wife. What promised to be a brilliant and useful career has thus been cut short at the early age of forty, but not before Maillard had been able to shed lustre on the service to which he belonged, and to win the friendship and esteem of his comrades.

Edith Frankham.

We are indebted to a former Sister Martha for the sad announcement of the death, from Blackwater fever, at the Mission Station of Beira, of Nurse Frankham.

By her unvarying kindness to her patients and strict attention to duty, she won the love and respect of all who worked with her at Guy's, and her recent labours in the mission field were so successful, that her loss will be long felt and her memory cherished.

Those who work in Foreign Missions have to face trials, which those at home cannot too highly appreciate. Edith Frankham's example may inspire others, that this work may be carried on without break or hindrance.

In Lighter Vein.

LECTURES TO NURSES.

Stirring Scenes.

Great Excitement.

It was a sweltering summer day in mid October, and I was wandering into the Park according to custom, when a curious spectacle met my eyes. Seated round the steps of the Henriette Raphael Nursing Home was a galaxy of ladies, some of them young, most of them beautiful, all of them nurses. They had adopted various attitudes in which easy grace was combined with a careful appropriateness as regards individual figure.

Some reclined against the trees and were subjects of great interest to the pigeons; others armed with umbrellas and wearing goloshes ("in case," as they explained, "it should rain") were sitting in conventional attitudes upon powerful campstools, whilst by far the greater number were stretched upon the sward. (Copyright.)

I was about to enquire the cause of this unusual assembly, when, on raising my eyes, a strange and unique procession could be seen approaching. In the forefront marched Prestige and a Medical Registrar [you know which one I mean] bearing staves of office, and emitting powerful rhonchi from funnyphones. Close at their heels, in bashful couples, came a string of twelve pink freshmen clad in white surplices specially lent by the choirmaster. Then followed what apparently was the *pièce de resistance*. Under a gaily-coloured palanquin, dramatically supported by Mr. Kenneth Black (basooning), Mr. Theodore Charles Pocock (buffooning), Victor Andrioletti and the Baker, sauntered Dr. Horace Cutler. Bringing up the rear was Mr. Alcock of Oldham, Lancs., agrin, who explained that he was a henchman, and begged that nobody would forget it.

The procession wound its way amid the trees towards the portico of the Home, upon the steps of which the bearers took their stand. The henchman then strode to the front, and cried in a raucous voice, "Silence for His Grace!" Upon which the hitherto silent and apparently nonchalant lecturer blazed forth into passionate speech.

(We have it on the authority of the Medical Registrar that at this point Dr. Cutler's temperature rose rapidly to 105°, a well-marked globus hystericus was visible on percussion, cooing bruits of the teuf-teuf variety, only more so, were felt at both bases, and a dull note was elicited in the flanks by Mr. Alcock.) [This is rot.—Ed.]

"Ladies," said Dr. Cutler, "Dear, dear ladies! After my recent, all-too-hurried excursion into the fascinating pages of a little red hand-book on nursing" (here he took a deep breath) "a book with which you are all familiar" (cheers from Esther pro.'s), "I set about me to consider a fitting title for this my consummate attempt to instruct you—an attempt whereby great profit will accrue to your elders and betters of the opposite sex, much credit will be gained by you, and no small honour and glory will fall to myself." [There was a lot of this stuff—we can only print extracts.—Ed].

(Loud uproar; cheers, in which the speaker joined. Excitement amongst pigeons.)

"After much deliberation I have decided to simply appeal to your moral sensibility, merely to beg of you that wherever you are, whatever you may be doing, you will at least—be good. It has been said by one, 'Be good, sweet maid,' and I would reiterate that injunction with all the fervour of an artistic nature."

* * * *

"In your manifold duties, you will find ample scope for the exercise of those qualities which rightly endear all good girls to their surgeons, physicians and sisters.

"Physicians, you will find, are harmless creatures. They never want you to assist them in making a diagnosis; they will merely, perhaps, gaze at you in their dreamy theoretical way, and at the most may wonder what colour your eyes are, and whether you come of sterling Puritanical parents."

(Here a "Lamb" burst into tears and was led away by Mr. Black.)

"For, my dear girls, many of you do most certainly suggest the passive resister, whilst

others of you are aglow with the conviction that your métier is the perfecting of the professional man.

"Surgeons you will find difficult to handle. True, there are some of the only-a-penknife variety who will leave you to your own devices, but there are others who are tiresome, and who may want you to hold things and help sometimes at operations."

* * * *

"I conclude my lecture with the following stirring couplet from Omar Khayyam—or is it Milton?—I forget the dose—

"'Like a little candle, so we must shine,
You in your small corner and I in mine.'

"The next lecture, dear ladies, will be delivered by my dear old friend and brother, Mr. Ralph Thompson, the subject being—'His bark is worse than his bite,' or Rudie! Rudie! Rudie!' with lime-light illustrations."

The cavalcade re-formed and returned to the college—the girls went home, and I was left alone.

QUEER FISH.

Appointments.

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Medical Council and approved by the House Committee:—

Clinical Assistants in Medical Wards.—Messrs. H. H. Jenkins (Dr. Taylor); M. G. Louisson (Dr. Hale White); H. M. M. Woodward (Dr. Pitt); E. C. Myott (Sir Cooper Perry).

Clinical Assistants in Surgical Wards.—Messrs. M. Bramley Taylor (Mr. Golding-Bird); A. M. Roome (Mr. Jacobson); J. Cook (Mr. Symonds).

Ophthalmic Dressers.—Messrs. B. Moiser, E. L. Ward (Mr. Higgens, November 1st); B. Muir (Mr. Brailey, November 1st); A. R. Wilson (Mr. Higgens, December 16th): L. H. Frankenberg (Mr. Brailey, December 16th).

Surgeons' Dressers.—Messrs. S. M. Wells, H. M. Clarke, H. P. Costobadie, F. M. Longson, L. G. Davies, F. Alcock (Mr. Lucas); R. Edridge, W. Reeve, L. Doudney, P. A. S. Dyson, A. B. Cocker, R. P. Lewis (Mr. Golding-Bird); E. C. Hughes, C. M. Stevenson, E. W. Sheaf, H. V. Mitchell, C. M. Wenyon, R. A. Chisolm (Mr. Jacobson); R. Felton, A. Leeming, H. D. Wyatt, R. O. Williams, T. Turner, M. Maher (Mr. Symonds).

Externs.—Messrs. A. H. Clough, A. S. Littlejohns, J. E. Scales, W. M. Mollison, A. R. Beaumont (November); G. C. F. Robinson, L. J. J. Orpen, L. Myer, J. E. Prentis, G. Russell (December); N. H. Oliver, A. Morris, R. W. Allen, H. M. Langdale, J. H. Clatworthy (January).

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

A Warning.

DEAR SIR,—I must apologise for attempting to fill up space in your valuable paper—but I claim that the subject, concerning which I write, is attracting the attention of many Guy's men, both junior and senior, at the present time.

Briefly, it concerns the Army Medical men, who are at present studying at the hospital.

If any casual observer walks into the medical wards on any morning in the week, his attention will be drawn to a crowd—there is no other word for it—surrounding one of the medical registrars. And on closer inspection, he will discover that some fifteen of that crowd are Army Medical men.

Now, sir, much as we may desire a high state of efficiency in the Army Medical Service, still we maintain that the medical registrar is for the medical ward clerk.

I myself have seen—and my evidence is also corroborated by others—a crowd of close on fifty men round a bed; and have counted five medical ward clerks (*first* three-months' men) on the outside of the throng, unable to approach anywhere near the subject of the demonstration.

If you allow fifteen ward clerks to each registrar, and some dozen men, up for the final examinations—and again add fifteen Army men—you have a crowd approaching fifty.

I have heard on the medical stairs the following: "Oh, it's no good your going up to ———, you won't get anywhere near him!"

The army men (who blames them?) are naturally keen on hearing and seeing all they can. And while we all recognise that they have come to the best hospital in London for clinical instruction, and can testify to their unfailing courtesy and politeness on all occasions, yet I, and many others with me, maintain that they should have their appointed teachers and times for instruction. That, sir, is my point.

Those of us, who look back to the hours (many years ago now) when we first realized what "bronchial breathing" was, and learnt to time that "cardiac thrill," will probably think of the morning rounds with the medical registrar.

Guy's, I am told, has made a name for its teaching of practical medicine. Long may it continue thus.

In writing as I have done, I believe that I have only stated the opinions of a very large number of hospital men.—With renewed apologies, yours very sincerely,

HAROLD MANN.

A Counterblast.

Dear Sir,—I should like to protest against certain statements which appeared in the Gazette of Oct. 10th concerning those who go round in the morning with the Medical Registrars.

In the first place, anyone who has so gone round, must know that the post-graduate men always keep in the background—never ask or are asked a question, and never examine a case until the clerks have all finished. The question, as to whether it ought or ought not to be profitable for qualified men to hear what is taught to clerks, is perhaps best answered by themselves. I have always understood that "physical signs" soon become rusty in practice. Is it not an injustice to the clerks to suggest, that they object to having questions asked them for fear that they should not be able to answer?

"RHONCHUS."

Case for Diagnosis.

Dear Sir,—With regard to this case, the notes of which were published in the Gazette of August 29th, you may be interested to hear that the trouble disappeared completely under treatment by Salicylates.—Yours truly,

WM. A. CARDEN.

Fraserburg,
Cape Colony,
September 26th, 1903.

A Case of Acute Pancreatitis.

Dear Sir,—In reply to the question asked by A. J. C. in the Gazette of September 26th, *re* the Case of Acute Pancreatitis, reported in the issue of September 12th, beg leave to state that the patient was a well-set-up man; he was certainly not stout, and appeared to have no tendency to obesity.—I am, yours truly,

K B.

United Hospitals' Hare and Hounds.

Dear Sir,—I should like to call attention, through the medium of your columns, to the fact that the Blackheath Harriers have again kindly placed their headquarters at the disposal of the above club, and all men interested in cross-country running, especially freshmen, are invited to turn out, so that there may be a good chance of Guy's retaining the Cross-country Cup. Ordinary runs are held on Saturdays at 3.30, starting from the Green Man, Blackheath. In addition to this, matches are being arranged against Oxford, Cambridge and Dublin Universities, Thames Hare and Hounds, Blackheath Harriers, Ranelagh Harriers, South London Harriers, Wellington College and Lancing College, the first match of the season being that against the South London Harriers, on October 24th. It is hoped that all cross-country men will turn out regularly, so that the club may be able to put a good team in the field.—Yours faithfully,

OSWALD S. NORTON.

Chapel News.

On Sunday, October 11th, the Harvest Festival was celebrated in the Chapel.

The decorations were concise and in good taste, and the congregation in the gallery, both morning and evening, speaks well for the popularity of the present form of service.

Although one may be allowed to regret that our good friend Mr. Larkin is missed at the organ, there is happily no occasion to make it a complaint, for his successor, Mr. Jones, is well worthy of the seat of honour.

The attendance of students in the choir was satisfactory to a degree, being practically double the usual number, and the music at both services was excellently rendered. It has been observed that the students' portion of the choir is at present largely composed of senior men, who often put themselves to considerable inconvenience for a good cause. Might not some of the junior students follow this excellent example?

Nursing News.

Matron's Office.

On October 8th, Nurse Wilkinson, head nurse in Addison, left the hospital, having completed her three years' training in August last, and Pro. F. E. Campbell was appointed to succeed her as head nurse.

The following probationers have been successful in the Nursing Examination on Thursday, September 24th:—Pro. Waterman, Barnard, Martin, Pulbrook, Woodward, Crerar, H. Whiteford, E. Yeates, Knapp, Bell, E. R. Smith, Auld, Kirby, Dredge, Leather, Ponzoni, H. Edmonds, Newton, A. Whiteford, L. Scott, Fraser, M. S. Adams, Clutton, Stein, Jones, E. M. Cooper, M. Tippetts, Shewell, Douglas, Mudge, Crocker, Sleigh, Pagan, Bevan, Blott, I. Holman, Hedgecock, Hucklesby, Rogers, Lowe, Coulson, B. Davis, Whittam, Jickling, Wright, Dibblin, Stones, Cawes, Seccombe, Gregory, Stanton, M. Campbell, Humphery, Nunn, Wrenford, E. A. Cooper, Woods, Rigby, Morton, Austin, Parkins, E. Wood, Parish, Hood, Bryant, Waldron, Butcher, Bailey, Munson, Needham, Daniels, Robinson, Withington, Faull, Taylor, Hillier, Leiders, Vance, Richardson, Jolley, M. Hughes, C. Evans, G. Evans, Arundel, Joyce.

Passim.

For all those who were fortunate enough to be present at the Physical Society's opening meeting, Dr. Goodhart's address will remain in the memory as a great intellectual treat. The audience was large, representing, as such audiences are wont to do, all the rungs in the hospital ladder. And if for once that ladder seemed to have lost something of its wearisome length, it was because it stood foreshortened in the presence of Sir Samuel Wilks. "Trained as I was in the school of Wilks," said Dr. Goodhart, and the truth of it seemed almost startling. We are all of us thankful, that the venerable President of the Physical Society is still able to come into our midst, to talk with us, feel with us, and above all, to jest with us.

For the senior members of the society the lecture must have been an extremely interesting expression of a distinguished physician's point of view. But for the young men it was more in the nature of advice from a man who "has attained"—one who grasps the threads of experience in an ordered bundle, who from an intensely practical knowledge is able to make old truths bite, and by pointing out the mystery of the so-called "common things," to lead the way to a broader conception of life.

One in Dr. Goodhart's position on that evening might well have said, with the well-tried healer of souls:—

> "And how shall I assure them? Can they share—
> They, who have flesh, a veil of youth and strength
> About each spirit, that needs must bide its time,
> Living and learning still as years assist
> Which wear the thickness thin, and let man see—
> With me?"

Certainly his mention of the sense of loneliness that overtakes the medical man, "must give us pause and think." For sooner or later all of us begin to dread that day, when there shall be no house-surgeon, no house-physician, no clinical assistant, not even an extension-dresser, and (more horrible still) no ward clerk, upon whose advice or assistance we can fall back. And to those of us who are beginning to dread that we may be incorrigible after all, the assurance that we can "worry through anything if we only make up our minds to do so," was as comforting as "the shadow of a great rock in a weary land."

During the course of the lecture many a profound diagnostician was seen to hide his diminished head, and towards its close distinguished surgeons, both young and old, could be seen blushing like school-girls.

Our entry of London men this year is a record one, being no less than sixty-three; thirty for the preliminary scientific, and thirty-three for the full course. The dental entry has now settled down again to its normal level, after the rush of men under the old regulations, which culminated in 1900. The entry of conjoint men is still on the down grade; ten years ago they outnumbered the London men by four to one, but now for the first time they are themselves outnumbered. With our excellent London entry, we bid fair to maintain our position as head of the schools of the London University, which has been won for us by the brilliant work of our men during the past few years.

If the reconstituted university is worked in a statesman-like manner, we may expect, as years go on, that all but a small minority of our men will take a degree. The only obstacle now remaining, which is at present, though we hope only temporary, a most serious one, is due, as we have before pointed out, to the preliminary scientific syllabus now in force. By an oversight for which everyone concerned appears to

be anxious to disclaim responsibility, the intermediate M.B. chemistry has been transferred bodily to the preliminary scientific year, without any extension of time, and it is to be hoped that in the interests of medical education in London, the Senate will lose no time in correcting what everyone now admits to have been a most unfortunate error.

Apart from this, there are many improvements in the new M.B., B.S. curriculum, and in particular some excellent innovations at the intermediate M.B., which are deserving of wider publicity. In future a man who fails (but not badly) in one subject only, will be able to take this subject alone at the next examination. All men will be marked for honours, as well as for a pass, as there will be only one set of papers; the best of the honours or "starred" men in each subject, will get the medal and scholarship, which will in future be given in January as well as in July. Modesty, which is much more common than cynics affect to believe, will thus be compelled to reveal itself, and with great advantage to all concerned.

There will be, we imagine, a general chorus of approval over the new anæsthetic appointments, the details of which are adorning the notice-boards in the colonnade. By the new regulations for the Conjoint Examination, men are required to be signed up for having given so many anæsthetics before they shall be eligible for examination. This will result in anæsthetics being less of a closed book for the qualified man leaving this hospital, who has not been fortunate enough to secure a house appointment. It will tend also to put the house-surgeon less into the position of a helpless anæsthetist at operations. The system of charts for each case which is to come into vogue, should also make the administration of anæsthetics by a beginner a more intelligent process than it has been hitherto.

The remarks made in our last issue anent the morning teaching in the medical wards, have resulted in our receiving two letters on that subject, which we publish elsewhere. There can be no doubt that the ward clerk has a very definite grievance. He is told at the commencement of his six months, that the Registrar will be his "guide, philosopher and friend," and it must be more than disconcerting for him to find, that he has to share that privilege with so many others, obviously his seniors. The "guide and philosopher" also must experience considerable difficulty in dealing with so variegated an audience. Is he to confine himself to "meat for babes," or is he to soar into diagnostic realms, whither no clerk (beloved of his fellows) can be reasonably expected to follow? If it is true, as our correspondent (who so ingeniously styles himself "Rhonchus") states, that the post-graduate man always stands in the background, then, from bitter experience, we fail to see what benefit that post-graduate man can obtain from the demonstration. In the nature of things, therefore, the present system is unsatisfactory, and cannot give the proper educational value that both parties have a right to expect.

Thanks to the great kindness of Mr. Robert Gordon, an excellent balcony has been built for Job ward, which is not only a great boon to the inmates, but also enables the ward to present a brave front to the outside world of St. Thomas's Street. It is indeed difficult to estimate the enormous practical benefit of such gifts as these, and if we may suggest an improvement on the structure as it now stands, it is the addition of a mural tablet, bearing the name of the generous donor and placed in a suitable position "that he who runs may read."

With these solid additions to that ever-changing structure, Guy's Hospital, may we

raise a wail of lamentation over the insecurity of the colonnade steps? A popular but somewhat portly junior member of the Staff, very nearly had a nasty fall through leaning against the rotten reeds that at present usurp the place of iron railings. Those dear iron railings we all knew and loved so well for their support and their comfort, cold though it might be, in times of anxious waiting for the tardy Staff.

The actual use that the stone slope adjoining the same steps is to be put to, still remains a mystery. Rumour as usual is busy with suggestions. It is to be an alternative course for the aged and the infirm who may be steering towards the "big door on the left." It is to afford small boys, bound for the "red lamp" and the dispensary, much innocent amusement in the way of a butter slide. Or again, patients are expected to fall over the edge when take-in's are slack and dressers unemployed. Of course we do not really believe these reports, but our curiosity is aroused and we are beginning to feel, like the small boy in the ghost story, that "something is going to happen."

During the last month the Gazette has lost two powerful local supporters. Mr. Stanley Hodgson, late Vice-President of the Residents, has severed a connection as a contributor on the spot, dating back to 1897. He was editor three years ago, and since then has contributed "Letters from Africa," and many an article in "Lighter Vein," whilst for many men who (however impossible it may seem) were once freshmen, his words of welcome are still green in the memory. Also in Mr. James Brydone, late Medical Resident in Bright ward, we have lost a most successful editor and a valuable and versatile contributor to our columns. We can only hope, that for the Gazette's sake and for old times' sake, these two gentlemen will not lose touch with the journal they so successfully piloted in days gone by.

The present time affords a very fitting opportunity for pointing out to men, the outlet afforded in our columns for that variety of literary energy which we feel sure exists, but is so difficult to gauge. Especially would we appeal to the junior men for contributions, for it is the young blood that is wanted in this enterprise as in all others. Only "Mahomet *must come to the mountain*," and though it may sound paradoxical, we can promise him that his anonymity shall be kept a sacred thing.

It is indeed a pleasure to hear from a reliable source that a highly-decorated functionary approves of the tribute paid to him by the talented author of the poem, "To October Freshers," that appeared in our last issue. He reckons that after a long and chequered tenure of office, what he does not know about the hospital is not worth knowing, but that what he does know is worth—dollars!

At the commencement of a new session, there are many appeals made to the freshman. We would add yet another to the list, and plead with him, if he be a songster, on behalf of the chapel choir. We gather that this choir is at present in a flourishing condition, but that it may remain so, it needs the support of the younger men, upon whose shoulders the several mantles of the present Elijahs may fall. If the singing men, who have recently entered the hospital, will consider this question, and decide to give up a few hours of their time on certain fixed dates, they will not only be aiding an excellent enterprise, but will also reap no small harvest of pleasant memories when their student life here is at an end.

The alterations shortly to be made in the neighbourhood of the surgery will be fairly extensive, and many an old and familiar landmark will disappear before the onslaught of the British working man. It is sad to think of so hallowed a spot as the dressers' room as being invaded by this destroying angel, and the depressing effect of a new environment is terrible to contemplate. In spite of this sentimental drawback, however, there are many hygienic attributes it is to be hoped the new abode will possess, which in the present room are conspicuous by their absence.

On Thursday next, October 29th, a general meeting of the Clubs' Union is to be held in the Physiological Theatre. Dr. Pye-Smith is to take the chair, and the Budget for the coming year is to be discussed. There can be no doubt that these meetings have not been well attended of late. Men are ready enough to criticise results of expenditure, but will not take the trouble to attend the general meetings and get a better knowledge of the workings of the Clubs' Union. That this is nothing more than their duty is obvious, and we hope that Thursday's meeting will be an exception to what seems unfortunately to have become the rule.

The Physical Society holds its second meeting of the session to-night, Mr. C. H. Robertson in the chair. It is to take the form of a Clinical evening, and it is to be hoped that there will be a very full attendance. The details of the meeting are to be found on the many placards at present adorning the walls of the Colonnade and elsewhere.

Change of Address.

Mr. A. M. Kempe, L.D.S., has removed from 53, Church Road, Bournemouth, to Carodjhi, Donoughmore Road, Boscombe.

Mr. Kenneth C. Ness, L.D.S., from Watford, to 28, Old Steine, Brighton.

Mr. Walter R. Wood, M.R.C.S., L.R.C.P., L.D.S., from 21 to 28, Old Steine, Brighton.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Guy's Hospital Pupils' Physical Society.

The First Meeting of the Physical Society for the Session 1903–1904, was held in the Physiological Theatre on Saturday, October 10th, at 8.30 p.m. At 7 o'clock, Sir Samuel Wilks, the Honorary President, the Presidents, several members of the Staff, old Guy's men and students, dined together in the College Reading Room.

At the meeting afterwards there were present, besides Sir Samuel Wilks and Dr. Goodhart, Drs. Stevenson, Taylor, Horrocks, Bryant, Fawcett, Craig; Messrs. Higgens, Brailey and Lane; Sir Alfred Fripp and Messrs. Targett and Fagge, and a large number of past and present students.

The minutes having been read, Sir Samuel Wilks, who was enthusiastically welcomed, rose from the chair to express his gratification at launching the Society once again upon a new session. He referred to his many years' connection with the Society and with the Hospital, speaking humorously of himself as an examiner in days gone by, and of the difficulties which students then found in reconciling their cut-and-dried text-book ideas, with the infinite variety of individual cases. He then called upon Dr. Goodhart, who, he said, was his "successor in the pathological department, and a teacher who never forgot the patient in treating the disease."

The address was listened to with the deepest attention, and its conclusion marked by loud applause. Votes of thanks were passed with acclamation to Dr. Goodhart and Sir Samuel Wilks, proposed and seconded by Messrs. Robertson and Brydone, Bolus and Palmer respectively. Dr. Goodhart and Sir Samuel Wilks having replied, the Society adjourned for coffee in the Histological class room, where exhibits were displayed of surgical instruments, new books, photographs and drawings, which were found of great interest.

Dr. Goodhart, in addressing the meeting, spoke as follows:—

Mr. President and Gentlemen,—Thirty-four years ago this session, I read a paper before the Students' Physical Society; like myself, the same then as now, and yet both it and I without a single molecule here to-night of what composed us then. That difference is all in favour of the Society, for it is still young, kept so by the annual shedding of its mature leaves; while I —well! only a few of us can tell what it is to have passed from the activity of the Hospital Staff on to the shelf of the evergreen prospectus. This is the thought that has inspired my address to-night. The same, yet not the same. What, then, is the link? Life has passed on.

Thirty-four years ago my paper was a pathological one, and I had no difficulty in its choice, bred as I was in the school of Wilks, and pathological I hope are still the majority of the papers read and discussed here. But it is less easy, at least, I have found it so, to play my part to-night, and this difficulty was not lessened by the

fact that when speaking to one of my younger friends as to subjects of possible interest, he gave me this bit of advice: "Don't preach too much." Now that advice, considering my audience, was no doubt sound, but it was none the less rather embarrassing for me, because I have ever been rather fond of that style of discourse, and you will have heard in your youth, and no doubt still remember in these your years of wisdom, that the Ethiopian *cannot* change his skin nor the leopard its spots. Mrs. Pipchin was a green gooseberry till the end of the chapter. This is worth remembering in the treatment of disease, when your effects seem to fail to follow their causes. The Ethiopian can *not* change his skin, nor can you change it for him. Need I translate? There is many a disease that you can *not* cure, many an effect that you cannot obtain, however much you may wish it were otherwise.

On the other hand, neither must you be too ready to assume that certain results are *due* to certain causes. It is an enduring difficulty in the practice of medicine, that it is impossible to follow the working of our means, impossible to be sure how far they have shared in the end.

You are dealing with Life: a force that you cannot master, that will have its own way, that alters and adapts material to its own ends in a most wonderful way. For example, we are none of us very long in our work without coming across the old man or old woman (don't forget this qualification) who for years has lived upon alcohol. I am sure that in such cases if, from our knowledge of physiology and pathology, we cut it all off, we shall be very likely to kill the patient. And why? Because in so doing we shall have neglected the good old axiom, that use is second nature. It is quite clear that our alcoholic, by a very gradual process, has so accustomed his vis vitæ to this strange sustenance, that by careful collaboration with other materials of the body, soup has been made out of leather, so to speak, and more than that, the stomach of such an one has gradually lost its appetite and digestion for what is good and wholesome. This is surely why the drunkard manages to eke out his miserable existence, and lives sometimes so distressingly long.

There used to be in that good but rather terrible book, Garrod's Materia Medica, at the end of the description of some of the drugs, a paragraph on its incompatibles. But that is all extra-corporeal chemistry. So strong is the constructive power of this force, that I do not believe it recognises incompatibility unless you explode it altogether.

But the particular aspect of Life upon which I would dwell more particularly, for out of it come some of the pitfalls of medicine, is health. I shall not attempt to define it, for it is easier to say what is disease than what is health; moreover, from the point of view that I take up to-night, I shall have to contend that some diseases may be counted as health. There is no common standard of health. Yours and mine are quite different things.

Inside the hospital we are ever striving to give health to our inmates. As I have left the cabinet, out-of-office candour compels me to say that we very seldom do so, although we often put them on the road thereto, and even perhaps leave them well in sight of the goal. But it is no great exaggeration to say, that within these walls we do not know much about health, except as we ourselves have the happy knowledge of possessing it.

Inside the hospital, I shall assert that approximately we know nothing of health, beyond this striving to attain it; and the *it* for us is the making the machine go *painlessly* and if we can *easily*, and we don't otherwise think about function, as function, over much. Oh! but we study physiology, I hear someone say. So we do; but what is physiology? Little more than a description of the garments in which your dry bones are clothed, and a few ideas of how they are supposed to be worn, a description of the mechanism of the machine; but it is not the machinery in motion. But it is this machinery in motion—the dynamics, not the statics, of our viscera—with which we have to deal, and this is a much more intricate and delicate matter.

I fancy that we often err by studying too much the mere details of the clock, rather than the timepiece as a going concern. And, by-the-bye, it would almost seem that there is a rudimentary vis vitæ in some clocks; there are certainly some that only go sick after the doctor has attended to them; there are others that are pronounced sound by the specialist, and yet will never go; others are again most touchy about draughts: others so excitable that if you do but touch them they strike or stop; so that really, could they only be shown to possess a liver in however rudimentary form, one would certainly incline to consider them alive, and to be suffering from some derangement of the functions of that organ.

In those periodical exhibitions that were in vogue a few years ago in London, the section devoted to machinery in motion, was the one of all others that attracted the popular curiosity. Was not that because we could there see life reduced to steam power, to something, that is, that we could more or less understand? And if such an exhibition were with us now, would not the motive power—at any rate its most up to date development, its life—be expressed in electrical energy, about which we by no means know so much, and which at present does not shape itself readily to the constraints and uses of mankind. But we must suppose, that in the not far distant future, electricity will become reduced to submission too, and then in the bye-and-bye beyond that, perhaps we shall advance yet another stage, and we may be able to deal with that as yet more subtle intangible *body force*, as it at present presents itself to us, that energy in the animal machine that vitalises it, and makes it go, and which we provisionally call life. Shall we even then have attained to the origin of all things? I wonder.

But until we can thus vitalise the machine, and set it, when at a standstill, at work again, by putting its works in motion, there is the all important link in the chain missing, and of this the physiologist can tell us nothing.

But it is just this very link, this function that in the practice of medicine we have to watch, and, if we can, control and invigorate this that in its haltings, impulses, vagaries of all sorts has to be interpreted, and managed, and as we say treated. And for this there is no common fund of knowledge from which to equip ourselves, and so we find in our hour of need that books are *silent*, and we are *alone*.

Ah, Sirs! Some, even here, must have felt the truth of this, and have made acquaintance with this loneliness. I doubt if there be any other calling to which it attaches. However well read and even experienced you may be, there are ever being presented to you, fresh situations that are absolutely new; questions that you have never been asked before; situations that must be dealt with; questions that need to be answered. You would give anything for information, but the pundits are silent, and you are alone.—Yes, alone!

Then are anatomy and physiology of no use to us? Is the diseased and worn out machine as we see it in the dead-house, a mere bit of paleontology? By no means. Without anatomy there could be but little advance in surgery; without physiology there would be scant chance of acquiring that profounder knowledge of which I am at present upholding the need; and unless we are well stocked with the information that comes of constant attendance in the post-mortem room, there can be little certainty or self-reliance—save that of ignorance—or pleasure in our work. Nevertheless these things are all but stepping-stones from their dead selves to deeper things.

Two men I know—thoughtful clever men, and each has done exceptionally well, but the one once told me, half in jest, that he had given up the use of the microscope as an instrument of light and leading; and the other that he did not make great use of the thermometer. The criticism of each was a similar one; that the instrument is so liable to mislead. There is a great deal of truth in that. Many a man, woman and child, is kept in bed day after day, even week after week, because there is some slight elevation of the temperature of the body, who, if we only knew the upshot—could see behind the veil of the future, would be much better up and in the air. Many is the man who suffers because we know too much of symptoms, and too little of what they really mean, as regards the course of a disease; because we are thus afraid of risks.

Bear in mind that I am not laying down rules for your guidance, I am only suggesting lines of thought to you, but I am sure that you must have often felt as I have, that occasionally a patient suffers in this way.

There are of course hundreds of cases to put against this occasional miscarriage, where the body temperature is more or less a guide to correct treatment, and so to the saving of life or expeditious restoration to health.

One may speak in similar terms of the microscope. Addicted as I was to the use of the microscope, in years gone by, I can remember cases where I reported some malignant growth to exist, where from the subsequent history of the case it was quite certain that that opinion was wrong. Nevertheless it is but scant justice on my part to say, that it is my belief that had it not been for those many hours I used to spend day by day at the microscope, I should not be enjoying the exceptional honour of addressing you to-night as a student amongst his fellows. And this because, as I believe, in thus trying to unravel the tangled structure of things, to puzzle out their how or their why, in ever so muddleheaded a way, to follow the morbid processes of early growth, early inflammatory changes, the vascular alterations that are to be seen in them, and in the fibroid changes of senility and decay—I don't care in what organ you may choose—you cannot help casting your eyes ahead, and building up a picture of the machinery as it is in motion, of energising the machine, it may be in some poor ignorant way, but which creates a feeling of some sort of intimacy with, and interest in, these vital processes, and you will find that ponderings of this kind provide you with numberless suggestions which help to explain or illumine the progress of disease; and they leave you much more equipped for a wise decision in the crises of action that are ever awaiting your ability.

To look down a microscope may be an absolute waste of time, if we merely see certain details of cell, vessel and fibre, or a sort of puzzle in which to find the answer. But if as you look—and it is scarcely possible to do otherwise—you see beyond it the living machine, and surmise how it works; you may be wrong in your conclusions, I care not if you are, but you become fired by a passionate longing to know more of so tantalising a mystery, and you provide yourself with a companion who never leaves you (I won't say conducts you to certain success in some line or other, though that would be true); but if you are a plain man you at any rate double your talent, and if you are fired with live coal from off the altar, can call up the responsive flash-light to the thoughts which men call genius, enables you to push forward the boundaries of knowledge.

Don't you think that ten drops of digitalis, or any other drug, given by such an one, must have much more *purpose* in it, than when given by another from the motive that he had been told that it was the proper thing to give?

I have taken histology as an illustration, because I know that some do regard it as a study that has no particularly close relation with the work of practical medicine, not because what I say does not apply as well to other studies. I should certainly hold that in all lines of thought if we do but look with the intense purpose of seeing in the *in*animate the *living principle* that lies beyond the borders of our sight, we *do* penetrate in some measure behind the scenes, in a way that is otherwise not possible.

I remember once a preacher in St. Paul's Cathedral being very much shocked with the laity, because they talked of some of the great characters of the Bible with an air of familiarity, such as they might do if they were in the habit of taking afternoon tea with them. Well, I

think it *is* some such intimacy, as that I am inculcating upon you to-night, with that life or spirit, or whatever you call it, by which we live and move and have our being; because I think that by diligently cultivating its acquaintance we become at any rate firmly convinced of its invincibility, its courage, and its rectitude. We come to recognise how difficult it is to kill; how it seldom gives in till it is dead beat; how it always runs to win—that is, it always does its best to make for the restoration of health.

And it is, in my opinion, this ever-present belief in this masterfulness and vitality of life, that constitutes one of the best working principles for the practice of medicine. There is no doubt that medicine is surrounded by many pitfalls, and this appreciation of life serves to keep us out of them.

For example, its tenacity and the surprises that it springs upon us in the course of a disease, the unexpected suddenness with which changes occur in symptoms, the difficulties that it places in the way of exact diagnosis, may well inculcate tolerance of opinions other than our own.

You know as well as I do that there are plenty of cases inside the hospital that present you with rare conundrums of diagnosis, and plenty that cause you much hesitation as to what is the best form of dealing with them, but it is nevertheless true that the case is comparatively infrequent where you cannot put your finger on plenty of actual disease. The question with us is more often how to put together the many pieces of the puzzle, upon which to start of the many signs of morbid change that seem to call for immediate amelioration. Yes, it is seldom that we do not find something.

To the *judges of first instance*, however, outside the hospital it is too often all the other way. Now, it is that function bursts upon us with all its bewildering variety and significance, and the bulk of sickness is indefinite. May those who entered on October 1st forgive me. We aim at being, and should be, very precise inside these walls, but cast your minds forward in all such cases, and have mercy upon your future self, when you shall be brought face to face with Mrs. Jones, who perchance has a headache and no appetite, and a nasty taste in her mouth, and a bad tongue in the morning, a pain here and an ache there, who thinks she needs a pill for her liver and something for the gout, and wants to know what she must eat, drink and avoid for her indigestion and her pimples, and so on. What to eat, drink and avoid! I wonder that any doctor lives even to middle age with such a nightmare as that for ever within his horizon. You may have made a great reputation amongst your fellows for your diagnostic intuition, and yet be ready to curse the day you were born when you need to construct a body out of the mere pieces of heads and tails of half the ailments that you are called to treat. Indeed, the only way out of many such an impasse would seem to be, to take it in the spirit of Mrs. Gamp's soliloquy, when she heard of the supposed death of her young friend, Bailey Junior:—"He was born into a wale, and he lived in a wale, and he must take the consequences of such a sitiwation."

And, by the way, this may apply to any, if there be such here to-night, who have entered, as some sometimes must, into the work of healing the sick, as a means of livelihood rather than from any feeling of distinct aptitude thereto. A man can worry through most situations in this world with fair success if he only makes up his mind to do so.

So I say, have mercy on your future self, when you shall be brought face to face with what appears to be all function, and try to keep the tip of your nose straight when you hear such diagnoses as "It is all gout," or "rheumatism," or "neuralgia," or any other of the vague terms that we poor fossils are at times reduced to. They are not all cloaks to carelessness. I am old enough to be able to spend a whole hour in defending the use of the word "gouty." They are simple recognitions of the impossible in diagnosis, a confession that after having diligently probed the various leads towards real structural change which the symptoms might be supposed to suggest, nothing has been discovered, and we are therefore driven to adopt some neutral term—not necessarily incorrect; on the contrary, which may be quite correct, but which may mean anything or nothing. In the common ailments of everyday life you *must* believe in functional troubles, and provided that you are alive to all the issues, why not?

There are those who say, that all abnormal function owns some definite change behind it, but that does not help you much if you cannot detect it. But I don't believe it in any tangible sense, any more than I believe we shall be able to show that a particular thought has wrought this or that structural change in the nerve cell that called it into being. I would rather hold that functional maladies are just hitches in the machinery rather than *diseases*, and that they do not, as a rule, bear much relation to the shortening of life. Nevertheless, it is they, that, by the discomforts that they cause, blind us to the resilience of life, and land us in a modern chemist's shop, and cures and quackery.

On the other hand, functional maladies may very well tend to correct the habit we incline to grow into where we see the most severe side of illness, of looking upon everyone who consults us as specimens of some irreparable morbid change. Thoroughly convinced of the tenacity of life, you are hopeful, and resourceful even when things look blackest, and when the surroundings are those of despondency, or even of despair. And hopefulness even unto death, is *necessary* for the patient, is good for the doctor, and good for the profession to which he belongs.

But there are some, nay many, who habitually put the worst possible interpretation upon every symptom, however mild. Everyone who appeals to them is not only so much disease, but very bad disease. Such people seem to have no recognition of the indomitable pluck of the living force. Curiously enough, although they are sometimes dubbed pessimists, and taken at a small discount,

they are generally considered by the public as good currency; and when, before long, the vitality of the patient asserts itself, and the sick man turns the corner, our Dr. Doleful is supposed to have performed a feat of skill by his treatment, and he sails away as a saviour quite illegitimately, which is a very serious matter for the advance of knowledge, and also somewhat so for the doctor too, for he runs the danger of ere long having to take with shame a lower place. It is not difficult to make a reputation, but it may be very difficult to live up to it. And as so often happens Dr. Sanguine, whose cause I would rather take in hand, and whom I consider to be the more generally wise man, is mostly damned by faint praise, for of him it is said: "Yes! he is a very good man if you are really ill, but then I don't want to be really ill, and so I go to Dr. D."

Nor do I much like those who are apt to talk of the *cure* of disease! "I cured this" and "I cured that" always seems to me to savour of a stiff-necked and narrow-minded presumption. We cure hams—not an accomplishment that is especially distinguished—disease gets well.

Yes! disease gets well, while we look on, and sometimes hinder, but generally assist as best we can.

Never assume a lower role than that. We speedily find ourselves in strange company when we begin to vaunt ourselves upon our power to *cure* disease.

If we knew more about health, we should think less ill of disease. There is indeed no more necessary acquisition in the whole range of medical study, than to have an extensive knowledge, not of disease, but of the range of health by which to truly gauge it. Let me illustrate this by an appeal to physical signs. It seems to be supposed by some, that physical signs and symptoms have for the most part a fixed value, but I very much doubt if you could tell me *any one*, for *any disease*, that does not bestow its smiles on several lovers. The value of each sign must be fixed against the background of the machine in motion—that is by the state of health that exists at the time. Bronchial breathing may mean serious disease of the lungs but it may equally well mean nothing of ill health, having regard to such qualifying conditions as the shape of the chest, the sex, the age and so on. No one sign is pathognomonic of any disease. Yet—I say it deliberately—no point is more often forgotten.

There are hundreds of people who daily, in this year of grace, are said to have dilatation of the heart, for the sole reason that its impulse is half an inch or so outside the limit that they are pleased to call the normal, and for them the unalterable limit. Others, again, are said to have valvular disease because there is some spurious murmur; others to have phthisis because there is the bronchial breathing of which I have spoken, and so on.

Therefore, let me say again, all symptoms and signs need to be interpreted by the working of the machine in which they exhibit themselves, and to be checked by knowledge of what is found in others who may be assumed to be healthy.

Examine all the healthy people you can, over, say, a year or two, and you will be astonished in how many there will be a heart that has an irregular action, or one that intermits a beat; kidneys that are movable; livers that are proptosed; stomachs that are baggy, and so on, to a very long list—conditions, all of them, that *may* mean disease, but which, when brought to the test of the going concern, most certainly do not handicap either life or health. The fundus oculi is another quarter that seems to me always to teach the need of a very large knowledge of health. At least, I can think of no region where a wider knowledge of health is so necessary to the right judgment of whether disease is there. Think for an instant how many times you have found it, how many times you will find it again, so easy to say, "This is disease"—some little cloudiness of the vessels, some little fulness, some slight injection or want of definition of the edge of the papilla associated, as the suggestion is, with symptoms that are equivocal. It is so easy to *say* "Here is early inflammation"; how difficult to be sure it is within the range of health. This needs an acquaintance with hundreds, perhaps thousands, of healthy eyes, and unless we are careful we are for ever looking upon diseased ones.

But I must go farther and say that there are many conditions, that although very abnormal, and, as such, may well be considered to be, at any rate, the beginnings of disease, yet are compatible with smooth and painless working of the machine, and a length of days that extends to its full term. Such an one is what we call functional albuminuria. This is a condition that, as far as I know, is not of any importance so far as present health or longevity is concerned. At any rate, it goes on for years without any symptom of ill-health, and it by-and-bye disappears. It would almost seem to have been discovered for the purpose of making people nervous about themselves: or for the keeping good business out of the way of life insurers, or otherwise eligible young men out of the services and large public offices. Mind you, it is a condition well worth study, in the physiology of the kidney or liver. If we could only say how it comes and what it means, we should doubtless know more of the function of these organs than we do, and more, perhaps, about the pathology of renal senility and decay.

Let me go even one step farther: not only do I maintain that it is a good working principle always to assume a man healthy until you can find such evidence of defective working in his organs that you are compelled to think otherwise; not only, if there be evidence of defective action, that it may still be compatible with that smooth working of the machine—that is the only definition of health to which I can attain; but that a man may even be the subject of serious and in the end fatal disease, and yet live on to the outside world and even to himself in the enjoyment of health for many years, is a warning strong and clear to us not to be injudiciously active in our well-meant endeavours to heal the sick.

Any number of illustrations might be given of the truth of this, but let the case of mitral stenosis suffice. The length of time that those so affected will live is astonishing, if only we let them alone and they can live a life of fair activity. If, on the other hand, we preach rest, rest, rest, to them, carry them up and down stairs, and make them avoid exertion of every kind, we certainly do our worst for them and tend very materially to shorten their days, and to antedate their day of suffering.

There are yet two other pitfalls that I would particularly mention before I have done; for, like the lady's postcript, I think them more important than any I have touched upon already. These are routine and the "itch."

And as regards routine, surely here again our vitality steps in, with its large margin—that each of us posesses—over and above what is necessary to sustain the weaknesses of severe illness. The human body appreciates regularity, but rebels against the monotony of routine. Do you doubt it? It is theoretically possible to live on so many food units of proteid and carbo-hydrate per diem, and even to get fat and thin by rule. Try it on your own person, make out a nice little menu, say of plasmon, which seems the fashionable proteid just now, and glucose, and a little fat, and bone ash salt and water. Stick to it steadily say for three months and let this Society receive a communication from you at the end of that time, for your experience cannot fail to be exceedingly instructive to those who come after you.

There are some people who can live on very curious foods. I don't so much wonder at that. Sports are of the essence of living beings and things—but what I do wonder at is, that whenever the occasional freak of this kind struggles to the surface, instead of lying low as the eccentric should do it, straightway tootles forth to all the world, "This is the way, walk ye in it." But the *natural* man will have none of it, he abhors routine. Surely that is why *week ends* are so refreshing. You change your cook.

But the great quarrel with routine in medicine is that it is such a blight on progress. It shuts the door on questions that are still open ones, and it ignores the many sided spontaneity of life. Perhaps certain forms of treatment will best bring out my meaning.

Years ago, John Hilton, never to be forgotten here, dwelt, as you all know from Mr. Jacobson's edition, in delightful manner, all his own, upon the value of rest in the treatment of disease. But he carefully safeguarded its need by the presence of pain. Rest seems so very natural a remedy that no wonder we have gone far beyond that, and often order it without due reflection whether it may not sometimes be harmful. Rest cures abound, but they do not always do good. Rest is a great and dominant aid to healing and health, but it does not follow, because a man shows signs of cardiac weakness, that therefore he must have his bed in the library, and be carried up and down stairs, and walk no faster than a crawl. After all our muscles were formed for *action*, and there is probably no more fertile source of disease in the world, whether it be in brain and muscle, heart or viscera, than ill-advised and prolonged rest. Bone-setting has read us that lesson.

Take again such a disease as Bright's disease, who can help but doubt whether the routine treatment of this disease, viz., completely changing a man's diet and purging him, is one that should obtain such universal acceptance as it has done. Nor can it be doubted that the customary flushing with salines, or even water, innocent as these measures may seem, will often disturb the natural habit, and do harm rather than good. Even in the more severe cases of much dropsy and albuminuria, acute as well as chronic, we who have lived long enough, have all seen such marvellous resistance to disease, such astonishing restoration to health even if slow, when recovery seemed impossible, that one comes to approach each and every case in the light of one to which no rule of thumb is applicable, and that good old axiom is ever to the fore, that you must treat the patient and not his disease. This is only one out of many cases that might be given, the open air treatment of disease might well be another; and it is fashionable just now. It is an excellent thing in its proper place, but it will not apply to all and sundry, and it is no cure as the sick man counts cure, it does but enable his vitality to reassert itself. The physiologist may speak of phagocytic action, but I still love the old idea, that mortality is swallowed up in life.

The practice of medicine is strewn with disappointments, because means, good in themselves under certain conditions, have been applied to purposes they could not be expected to accomplish. There are many reasons, no doubt, why this is so, but one of the main ones is certainly this, that when occasion calls we fear to modify the dicta of the past. "This, is good for that" was handed over to us by someone whose opinion had earned its title to respect. "Who am I that I should question authority such as this?" we say, and thus we pass on and continue to do what the fathers have done. But we *must* question authority. Our teachers are not lawgivers; they exist in order that we may become a law unto ourselves; they are of the bacterial order, their action is zymotic; they are ferments to instigate us to appropriate thought. Their position is antitoxinic to routine. The experience of the past of which they tell—for even yesterday has gone—is entitled to, and should receive, a most reverent consideration. Coming as it does o'er the hills of time, there is sure to be substance in it, but it fails in function if it be not assimilated and adapted to the special occasion, and so passed on, bettered by the using.

Little time is left me to deal with the Itch, prevalent though it be. To the late Sir William Gull is attributed the saying, that there are three things one must at times make mistakes over—tubercle, syphilis, and itch—but the malady of which I speak is quite another one. The disease or pitfall that I have in mind has, it is true, an equally characteristic eruption, and it is contagious, but it comes on in those who, though of good health, are

perhaps a little too full-blooded with energy and enthusiasm. The eruption sometimes comes out well, and some there are that have it rather severely, and like many of the eruptive disorders it may be difficult to distinguish at first sight from things that are good and wholesome. Need I add that the trouble I allude to is the *cacoethes medicandi aut secandi*, or the itch to do something.

What better corroboration of its existence could there be than the nearest chemist's shop, or the bewildering deluge of pamphlets and advertisments and touts for new drugs that in one form or another are assailing us all day long. We take and give far too much medicine, and this is largely for the mere daily hitches of function that any machine in constant use almost necessarily experiences, and that in an automatically repairing arrangement such as ours will almost certainly right themselves if we wait. There can be no doubt that it would be better if we did less and waited more, so far as drugs go. Not that the occasion for drugs is to be unduly narrowed. For the encouragement of hope, and because of the darkness of the road that is before us, it will often be necessary to administer drugs, to order treatment, the outcome of which may be very uncertain, and of which the immediate prospect of service is almost nil. Nevertheless it is part of our duty, whenever it be possible, to educate the public, and from this time-honoured society must come all that is best of light and leading.

And for surgery, too, would I act the part of the candid friend. Ours is a profession of moods.

Years ago, in reaction, I suppose, to the heavy mortality attending all major operations, the mood was conservative, as it was called. Within well-considered limits it was, no doubt, a wise mood. To-day, in all directions, our accomplishments are so great that we are all for doing something. "We can't do any harm," we say, so if we cannot make a diagnosis, or do not know quite what to do if we can, we say let us "Look and see." And the exploratory operation has become a routine. This has been attested by some of our wisest and more experienced surgeons. We are meddlesome with our drugs and with our knives, we cannot wait and watch, we have no sufficient confidence in the vis vitæ of which I have said so much to-night, and this mood is assuredly not to the best interests of medicine or surgery.

But it will be said that this is a plea for doing nothing; it would deaden all enthusiasm, and it is by enthusiasm that most of our advances come. But I demur. It is a plea that enthusiasm shall ever be tempered by a deliberate judgment, and by that I mean a determined effort on the part of the mind, be it even in the ordering of a poultice or a bath, to exclude bias, and out of any choice of possible courses to choose the one best fitted to the patient in case. The habit of mental effort in the weighing of pros and cons controls the itch; it thus confines drugs more nearly to their proper sphere; uriosity has no part in exploratory operations then, and operations of doubtful utility are only undertaken when the chances of success squarely meet the risks.

These, sirs, be some of my very thoughts. In deciding to put them before you, however wanting they may be, it was my wish to show to the Presidents of this Society how much I appreciated their request that I should open this your first meeting of the session. Would that the measure of my pleasure had been more adequately repaid to them.

Guy's Hospital Physiological Society.

At the fourth general meeting of the Physiological Society, held on October 15th, it was announced that the President had offered a prize for the best paper read during the last session, and that the winner would be announced at the next meeting.

There was a balance in hand, and it was decided to spend part of this in buying books for the Physiological library. Members are now allowed to keep the library books for a fortnight instead of only three days, the time previously arranged.

The following officers were elected for 1903–1904:—President, Dr. Pembrey; Vice-Presidents, Dr. Beddard, Dr. Spriggs and Mr. Forsyth; Secretary, G. F. Stebbing; Committee, Messrs. W. H. Miller, E. W. Giesen, J. L. Rankine, G. Cockcroft, G. F. E. Allison.

From the Gazette's Special Pathologist.

All specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. Wells.

NOTICES.

J. P. P., Ormskirk.—The flakes present in this specimen consist of mucus coated with degenerated columnar epithelia from the intestine associated with a few leucocytes The structure is identical with that of the mucous cylinders which are often passed in cases of muco-membranous colitis.

PATHOLOGIST.

Specialities.

BYNO-HÆMOGLOBIN.

Byno-Hæmoglobin has been a clinical success. To the ill-nourished infant the value of malt has long been recognised, and in some form is usually prescribed with iron. This compound contains both, and in a palatable form that the patients like, and it appears, at least, to be as successful as any other compound in improving nutrition and restoring the richness of the blood corpuscles.

BYNO-GLYCEROPHOSPHATES.

Byno-Glycerophosphates is not so easy to speak of, its value cannot be estimated so easily, but it is palatable, and does distinct good, as a prescribable form of two valuable remedies.

We have received from Messrs. Edward Cook & Co., Ltd., the Soap Specialists, a sample of their new Soap "Lasso." It is claimed for this soap that it will remove grease and stains, and that dirt, however ingrained, will succumb before it. It has also the additional advantage of a pleasant odour, and will readily lather with cold water. We have tried this soap and find that it possesses all these qualities to a marked degree, and we can therefore thoroughly recommend it for toilet and household use, while as an additional item to the cyclists' and motorists' outfit it should be indispensable.

Sport.

Rugby Football.

GUY'S v. LENNOX.

The opening match of the season was played at Honor Oak Park, on Saturday, October 10th, and resulted in a win for Guy's after a good game. The result was most satisfactory, as we had six new men playing.

Guy's kicked off, and at once attacked the visitors' line. The Guy's forwards were getting the ball well, and two attempts by McEvedy and Morgan to break through were prevented by the good collaring of the Lennox three-quarters. The Lennox forwards then rushed the ball down the field, and after a scramble near the half-way line, Morgan obtained possession and raced over, scoring under the posts. No goal resulted. Soon after the kick-out, Saunders picked the ball up well after a forward rush, and registered the second try. Lennox attacked after the kick-out, but good kicking by Harrison saved. The ball coming well out of the scrum, passed through the hands of all the backs, and finally reaching Morgan, enabled him to score his second try. Harrison failed with the kick; and after a good rush and collar by Mullins, half-time was called, with the score: Guy's, 3 tries; Lennox, nil.

Lennox had much the best of the second spell, the Guy's forwards being beaten in the scrum every time; however, Harrison's good kicking and collaring prevented several scores. Lennox at once attacked after the kick-off, and but for a good collar by Morgan, would have scored. Wilkes, for Lennox, and Archer, for Guy's, were noticeable for good play. The Lennox half, passing the ball out on the blind side, enabled Nelson to score an easy try near the corner. After this, play was more even, both sides tackling keenly, and no side was called with Guy's, 3 tries (9 points); Lennox, 1 try (3 points).

Remarks.—Both backs and forwards, with a few exceptions, were very much out of condition. Harrison, at back, played his usual sound game. The three-quarters did not play well together, Orpen being chiefly at fault. Jones, at half, kicked and collared well, but should stand closer up to the scrum. The forwards played well during the first half, Pinching and Saunders being always on the ball. Of the new men, Archer and Mullins were the best. All the forwards should pack tighter, and when the opposing side get the ball, should break up sooner.

GUY'S 3rd XV. v. PARK HOUSE "B."

This match, played at Catford Bridge on Saturday, October 17th, resulted in a win for Guy's 3rd by 9 points to nil. The game was fairly fast, the Hospital 3rd pressing most of the time. Baker collared well, and Williams played a good game forward.

The following men represented the 3rd:—C. H. Marshall, H. F. Wright, W. A. Helyar, T. L. Baker, W. A. Watson, Thomas, Myott, D. Reynolds, D. Doudney, B. B. Metcalfe, W. Dicks, W. E. Williams, Kidd, Stevenson, Roberts.

GUY'S 3rd XV. v. KING'S COLLEGE ENGINEERS 2nd XV.

This match, the first of the season, was played at St. Quintin's Park on Wednesday, 14th inst., and resulted in a win for the hospital 3rd by 15 points to nil. It was entirely a forwards' game, the wet state of the ball preventing the three-quarters from doing very much.

The team consisted of:—C. H. Marshall, E. Wacher, W. A. Watson, W. Helyar, H. G. Gibson, T. R. Harvey, T. L. Baker, L. L. C. Reynolds, D. Reynolds, M. E. Ball, B. B. Metcalfe, D. Doudney, H. E. Perkins, S. Wick, S. M. C. Saunders, C. O. Roberts.

The following men scored:—Ball, 2 tries; E. Wacher, 1 try; C. H. Marshall, 1 try; S. M. C. Saunders, 1 try.

United Hospitals Hare and Hounds.

The annual general meeting of the above club was held on October 13th at Guy's Hospital, P. Gosse (St. Bart.'s) being in the chair, the principal business on hand being the election of officers. It was learned with regret that P. Gosse and O. S. Norton, who respectively fulfilled the offices of captain and hon. secretary last season, were compelled to resign these positions.

As regards fixtures, it was announced that matches had been arranged v. South London Harriers for October 24th, and v. Blackheath Harriers for December 5th, and that communications were in progress for the arrangement of suitable dates with Oxford, Cambridge and Dublin Universities, Ranelagh H. and Thames H. & H.

After a vote of thanks to O. S. Norton for his valuable assistance to the club during the past season had been passed, a resolution was carried to hold the Inter-Hospital cup race before Christmas, if possible. The following officials were elected:—President, Percy Furnivall, Esq., F.R.C.S.; Vice-Presidents, L. A. Dunn, Esq., F.R.C S., C. H. Fagge, Esq., F.R.C.S., H. Morley Fletcher, Esq., M.D., and H. B. Robinson, Esq., F.R.C.S.; Captain, G. A. Simmons (St. Thomas's); hon. sec. and treasurer, T. E. A. Carr (Guy's); Committee, J. G. Gibb (Bart.'s), P. Goss (Bart.'s), O. S. Norton (Guy's), E. L. Pilbeam (Guy's): G. W. Lloyd (Bart.'s) and A. C. Wilson (Bart.'s). A vote of thanks to the chairman terminated the meeting.

Pavy Gymnasium.

At a meeting held October 13th, A. W. Ormond, Esq., F.R.C.S., in the chair, it was decided to start the following classes in the Pavy Gymnasium at once:—General gymnastics (Tuesdays, 4 to 6), boxing (Thursdays, 4 to 6), fencing (Fridays, 4 to 6). As it is owing to the generosity of Dr. Pavy in providing the funds for instruction, the committee hope they will be well attended.

It was also decided to start massage classes if a sufficient number of names are sent in to the Secretary.

Papers by Guy's Men.

Notes of a Case of Operative Treatment for Cirrhosis of the Liver. By William Sheen, M.D., F.R.C.S.—*British Medical Journal*, 10th October.

On a Method of Treating by Operation Paralysis of the Upper Root of the Brachial Plexus (Erb-Duchenne Type). By A. H. Tubby, M.S., F.R.C.S.—*Ibid.*, 17th October.

A Case of Diabetic Intraocular Lipæmia, in which the Blood was examined during Life. By W. Hale White M.D., F.R.C.P. Lond. (Illustrated).—*The Lancet*, 10th, October.

Appointments.

CIVIL.

Bridger, J. Dell, L.R.C.P. Lond., M.R.C.S., has been appointed Resident Medical Officer to the Surrey Dispensary, Great Dover Street, S.E.

Sutcliffe, John, M.R.C.S, L.R.C.P. Edin., has been appointed Senior Assistant Medical Officer, Royal Asylum, Cheadle.

NAVAL AND MILITARY.

Staff-Surgeon E. P. Mourilyan, M.B., R.N., has been appointed to the Medical Department, Admiralty.

Staff-Surgeon Norman L. Richards, R.N., has been appointed to the *Barrosa*, and Surgeon E. S. Tuck, R.N., to the *Cambrian*, additional for the Ascension Hospital.

Surgeon-Lieutenant F. Loud, 1st Sussex Royal Garrison Artillery (Volunteers), resigns his commission, and is appointed Captain.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only

Birth.

GODSON.—On October 13th, at 63, Union Street West, Oldham, the wife of A. H. Godson, B.A., M.B., B.C., F.R.C.S., of a daughter.

Marriages.

MUMFORD—MANSER.—On October 8th, at the Church of St. Barnabas, Tunbridge Wells, by the Rev. Arthur Reeve, rector of St. Mary's, Newmarket, and the Rev. H. S. Iredell, vicar of the parish, Charles Allan Mumford, I.C.S., eldest son of the late Charles Mumford, C.E., of Downham Market, Norfolk, to Hilda, daughter of Frederick Manser, M.R.C.S., of the Priory, Tunbridge Wells.

ROBERTSON—JONES.—On October 14th, at St. Paul's Church, Hampstead, N.W., by the Rev. H. W. Jones, B.A., Brooklands, Cheshire, brother of the bride, assisted by the Rev. L. A. Hughes, B.A., Bulford Camp, Salisbury Plain, Captain James Currie Robertson, I.M.S., to Catherine Ann, youngest daughter of Mrs. Rowland Jones, Lampeter, South Wales.

Death.

STURGES JONES.—On October 21st, at the Willows, Chichester, Charles Sturges Jones, M.R.C.S., L.R.C.P., second son of the late Rev. Edward Jones, rector of Milton Keynes, Bucks, in his eighty-first year.

Ed.—R. E.

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Calendar of Coming Events.

November, 1903.

Sat. 7.—Messrs. Symonds and Steward's take-in; Drs., R. O. Williams and T. Turner; Cl., C. H. Reinhold.
1 p.m., Clinical lecture by Dr. Hale White.
G.H.P.P.S., "The Use and Limitation of Blood Counting," by Mr. G. Russell.
G.H.R.F.C., II., v. Rosslyn Park II., away.
III., v. Kensington III., away.
G.H.A.F.C., I., v. Reigate Priory, away.
II., v. Cheshunt II., home.

Mon. 9.—1.15 p.m., Clinical lecture by Mr. Higgens.
Cambridge First, Second and Third M.D. Schedules to be brought to Medical School Office for signature.

Tues. 10.—1.15 p.m., Clinical lecture by Mr. Lucas.

Wed. 11.—G.H.R.F.C., II., v. Bart.'s "A," home.

Thur. 12.—Messrs. Lucas and Lane's take-in; Drs., F. Alcock and F. M. Longson; Cl., J. Goss.

Sat. 14.—1 p.m., Clinical lecture by Dr. Taylor.
G.H.R.F.C., I., v. Streatham, home.
II., v. Old Dunstonians, away.
III., v. Royal School of Mines II., away.
G.H.A.F.C., I., v. Old Westminsters, home.
II., v. Carshalton Park, away.

Mon. 16.—1.15 p.m., Clinical lecture by Mr. Steward.

Wed. 18.—1.30 p.m., Clinical lecture by Mr. Golding-Bird.
G.H.R.F.C., III., v. Blackheath School, away.
G.H.A.F.C., I., v. Emeriti, home.

Thur. 19.—Messrs. Golding-Bird and Dunn's take-in; Drs., R. Edridge and W. Reeve; Cl., W. F. Box.
G.H.C.U., Address by Sir Robert Anderson, K.C.B., LL.D.

Fri. 20.—Meeting of the Dental Society at 4.15 p.m.

Sat. 21.—1 p.m., Clinical lecture by Dr. Taylor.
G.H.R.F.C., I., v. Old Merchant Taylors, away.
II., v. Rosslyn Park II., home.
III., v. Ealing "A," away.
G.H.A.F.C., I., v. Beckenham, away.
II., v. Beckenham II., home.
G.H.P.P.S., Pathological Evening.

Guy's Hospital Gazette,

NOVEMBER 7, 1903.

Adherent Pericardium.

CLINICAL LECTURE BY DR. W. HALE WHITE.

October 10th, 1903.

GENTLEMEN,—Here is a man who came into Clinical ward a few days ago; and when we saw him it was quite obvious that the heart was considerably hypertrophied; and that fact I can easily show you now. You see that the impulse is in the sixth space, well at the bottom of that space; and if you put your hand over it you can feel the heart thumping very hard. As it was quite clear that our patient was suffering from a hypertrophied heart, the question came before us, What were the causes of hypertrophy of the heart? We knew the heart to be hypertrophied because the impulse is down at the lower part of the sixth space, and under the seventh rib, but only a little outside the nipple line. The causes of hypertrophy of the heart are very quickly put. Or perhaps I had better call them the causes of *considerable* hypertrophy of the heart, because many of us perhaps get trifling hypertrophy. First there is valvular disease; (2) chronic Bright's disease and arterio-sclerosis, which often go together, so we will put them together; (3) adherent pericardium; (4) alcohol. It is quite clear that we can bracket the first two as being very common; the hospital always has in it patients whose hypertrophy is due to valvular disease, or to chronic Bright's disease or arterio-sclerosis. Adherent pericardium is a common cause, but alcohol is rare. But recently, you will remember, there has been a man in Addison ward suffering

from alcoholic hypertrophy; and there is at the present moment a man in John, in whom the question has been raised as to whether he is suffering from a large heart because he has been taking an excess of alcohol. That adherent pericardium will enlarge the heart this museum specimen will show. Even at that distance you can see the enormous size of the heart, and I should think you can see that the pericardium was adherent. And the specimen is of some historical interest, because of its antiquity. It is a heart which weighs twenty ounces, and the valves are healthy. You see there is no valvular disease to explain this hypertrophy which is really due to an adherent pericardium. The description says, "It is surrounded by its pericardium, the two surfaces of which are firmly united by organised adhesions. The organ is considerably hypertrophied and its cavities dilated. The valves are healthy and it weighs twenty ounces." It is of special interest because the patient, who was aged 26, was admitted into Guy's Hospital as long ago as 1830. So you see we have been able to show you that an adherent pericardium is, apart from any valvular disease, a cause of hypertrophy of the heart. Now, in many acute diseases, such, for instance, as scarlet fever, typhoid, diphtheria, pneumonia and influenza, there may be dilatation with some hypertrophy, but the dilatation in those acute cases overshadows the hypertrophy altogether. And what I want you to notice is, that in this particular patient who has kindly come here to show himself, the hypertrophy overshadows the dilatation, for although you find such a heaving impulse, it is nevertheless very little outside the nipple line. And that shows that inasmuch as the impulse is low down but only a little outside the nipple line, the hypertrophy is much more marked than the dilatation. You will say, to which of the causes we have mentioned would you ascribe this patient's hypertrophy? He has not got chronic Bright's disease, nor arterio-sclerosis. We have been over that point, and he is too young for such a condition to be likely. Nor is there the slightest evidence that his cardiac hypertrophy is due to over-indulgence in alcoholic drinks. So we are narrowed down by his case, as to whether the hypertrophy is due to valvular disease, or to adherent pericardium. That he has got valvular disease there is no doubt. The first day we listened to his heart, we heard a long systolic murmur occupying the position of the first sound; and immediately after the second sound we heard a diastolic murmur fading away; and then an interval before the first sound again. That diastolic murmur indicated that the man had mitral constriction, for the murmur was heard just at the place where such a constriction murmur is heard, and was accompanied by a marked diastolic thrill synchronous in time with the diastolic murmur; so that anybody listening (the merest beginner) would have said rightly, that the man was suffering from mitral constriction and regurgitation. Therefore it would be quite open to anyone to believe that mitral disease was the cause of this patient's cardiac hypertrophy. However, I venture to think that the mitral disease is not the cause of the hypertrophy, for I think the point about the case is that the hypertrophy overshadows the dilatation. Now, if a man has such an enormous hypertrophy as this is, as a result of mitral disease, the heart will be very dilated, and the impulse, instead of being only just outside the nipple line, would be right out in the mid-axillary line. For this particular heart to be the heart of mitral regurgitation we should expect it to be very much more dilated than the forcible impulse and the position of the impulse show that it is. Further, if it were so, if this patient was suffering from mitral regurgitation, we should have expected that by now there would be backward pressure signs, such as cyanosis, a big liver, œdema of the feet, and so forth. But those are absent from this case. Consequently we conclude that his valvular disease was not the cause of the hypertrophy of the heart. You may ask me, in answer to this argument, May it not be that he has aortic disease? I quite admit from the position of the impulse and the hypertrophy of the heart, that this is just the sort of heart that you would expect with aortic obstruction, that is to say, a considerably hypertrophied left ventricle, with the apex downwards and not very much outwards. But unfortunately for

that view there is not, on listening to the man or feeling his pulse, the smallest evidence that the aortic valves are implicated. We may say, indeed, that they are certainly not. So we have decided that valvular disease did not account for his hypertrophy, that he had not had too much alcohol, that he had not got Bright's disease, and therefore we believe that his hypertrophy is due to adherent pericardium. He lay in No. 6 bed in the ward, which is badly off for light, so, having got thus far in thinking about the case, we turned the bed round to face the light, and then we found undoubted evidence that our view was right. And it is because that evidence is so strong that I brought him here to-day, in the hope that you might be able to see it a great distance. If not you can see it in the ward afterwards. The point that convinced us was, that with every contraction of the ventricle the ribs, on the left side especially, are drawn in. That is a pathognomonic sign of adherent pericardium. The way to interpret it is this, that there has been considerable pericarditis; the pericardium is, as you know, adherent to the diaphragm. The heart is adherent to the pericardium, the heart is hypertrophied, and every time it contracts it drags on the parietal layer of the pericardium, which, being attached to the diaphragm, drags on it and so draws in the lower ribs. All of us in John ward are convinced that this is well marked. Indeed, so well marked is it that Mr. Box constructed some levers which are put upon the patient's lower ribs and show this systolic retraction. It is a very striking sign. It usually occurs best at about the eighth rib in front, and the eleventh and twelfth behind. Other similar phenomena are, that sometimes there is a systolic retraction over the impulse of the heart. Every time a systole takes place, owing to contraction of the apex and the pericardium being adherent, the wall of the chest over the impulse beat is drawn in. That is not very evident in him. Another thing which occurs in these people is, that owing to the fixation of the diaphragm to the heart, the diaphragm does not descend very well on inspiration. Respiratory movements are always much better to see than the cardiac, and I think those of you who are near will agree that that diaphragm is at the present moment not descending very well in inspiration. That is because the pericardium is adherent. Another point, owing its existence to these adhesions is, that the apex of the heart in adherent pericardium being fixed, when we bend the patient over laterally, the cardiac impulse does not fall over, but this sign is absent in our patient. Of other signs which are indicative of an adherent pericardium, he has certainly got one, namely, that the impulse is very wavy. Two other signs given in books, but which we cannot find in him, are: (1) That there is a diastolic shock described as being present when you put your hand over the heart. I am bound to say I cannot convince myself that there is anything abnormal in the shock of the heart here; but it is described as a very interesting sign. And another sign is one which we are much interested in here at Guy's, because it was first described by our late Registrar, Dr. T. Fisher. There is no doubt whatever that you do see patients in whom you hear a presystolic murmur, and in whom, after death, the only cause for the murmur that can be found is adherent pericardium; the valves are perfectly healthy. But in our patient, for reasons I need not go into in detail here, the presystolic murmur which we hear is due to actual mitral constriction. One or two obvious reasons for saying that, are that when a presystolic murmur is due to adherent pericardium your patient is nearly always a child; and another is, that in such a case the presystolic murmur would probably not be accompanied by the systolic murmur. A third reason is, that in such a case the murmur would be distinctly presystolic, and not, as in this patient, an early diastolic murmur.

Naturally, we next tried further to prove whether our view that this man's pericardium was adherent was correct. He told us that he had been in the hospital before, and that he had had rheumatic fever. Rheumatic fever makes pericarditis very likely; but we looked up the references to his old report, and I find that when he was in the hospital under Dr. Frederick Taylor the diagnosis made was mitral stenosis and regurgitation, and adherent peri-

cardium. So as others have independently come to the same diagnosis I think we may take it as correct, and the patient does serve to show us what are the symptoms of adherent pericardium.

I will now go over with you the clinical points of adherent pericardium. For clinical purposes you can divide the condition into the three following groups: First, those in which adherent pericardium is of no importance to the patient. Second, those in which it is of serious clinical importance owing to cardiac symptoms. Thirdly, those in which it is associated with pleuritic and peritoneal adhesions. I think you will find that nearly all cases of adherent pericardium will come into one of these groups. Before we can discuss them I think you must remember a little about the functions of the pericardium. You must remember that, in the first place, it does not owe its importance to its being a serous membrane. Were that so, there would be no cases of little clinical importance. Its great value is that it is a support to the heart, and prevents its over-distension. You know that the physiological work of Leonard Hill and Barnard has shown that undoubtedly, if you take the pericardium away, you can distend the heart very much more than you could before. The chief function of the pericardium, indeed, is to prevent over-distension of the heart during muscular effort. When pericarditis occurs this fibrous sac becomes soft and pulpy and sodden, so that it no longer forms a strong support to the heart. Then you have to remember, too, that pericarditis is often associated with myocarditis. You can often see in the post-mortem room, a thin layer of yellow muscular substance immediately under the inflamed pericardium. You have therefore to remember that both the wall of the heart and the pericardium are softened and weakened by pericarditis, so it is very little wonder that the heart cannot any longer withstand any increased intracardiac pressure, and therefore it rapidly dilates. The next step in my argument is, that if the heart dilates it must hypertrophy. You know that the amount of work which the ventricle is called upon to perform increases very rapidly indeed as the radius of the curvature of the ventricle itself increases, so that a very little dilatation means a great deal more work for the heart, and consequently the heart hypertrophies. If, therefore, it begins to dilate, as it often does, as a result of pericarditis, hypertrophy will soon follow. And quite apart from any endocarditis, hypertrophy of the heart, everybody is agreed, is a frequent result of pericarditis. You see it in this specimen I showed you just now. There is no endocarditis, but the heart weighs twenty ounces as the result of pericarditis. And then Dr. Goodhart has recorded a case, for instance, which I took at random from the Pathological Society's Transactions, in which the evidence showed that in an acute case the heart weighed nineteen ounces at death as the result of pericarditis. There is worse to come in many instances. If the adhesions are of the tough variety and form when the heart is dilated they will hold it out and prevent its ever contracting up again. So you see the heart then cannot possibly get back to its normal size. It will remain dilated, and hence the patient probably becomes a permanent invalid, and the case is often made worse because adhesions have formed also on the outside of the pericardium to the pleura. There is nothing, that I know of, that can be done for such a condition. The old tough firm adhesions hold the dilated heart out; and however much the patient's heart—as one may express it—wishes to contract up again and become normal, these adhesions left by the old pericarditis hold it out. You must never plume yourself that you have cured a case of pericarditis properly, just because the rub disappears and the temperature falls. Your treatment of pericarditis has never been successful unless the adhesions take place on a heart that is not dilated. I quite admit that with our present therapeutic remedies we frequently fail to attain this, especially when there is endocarditis present; but when we fail we are in the position of a surgeon who, in a case of fracture, has failed to get the man to walk properly because he has got the bones united in a bad position. You see the whole crux of the prognosis in pericarditis lies in this: Does the pericardium become adherent when the heart is of natural size? If it does, no harm results, because the

main function is not that of a serous membrane. If the heart is dilated when adhesions form, then the patient probably becomes a chronic invalid. That, if the organ is not dilated, the presence of adhesions does not very much matter I can easily prove to you. For example, Wilks and Moxon say, "The heart is found universally adherent to its serous covering by means of a most delicate areolar substance, and no evil appears to result from it. Our own opinion is that simple pericardial adhesion produces no appreciable untoward consequences." What is meant is, that the mere adhesions in themselves provided the organ is not dilated, are of no harm. Sequirà says: "It is quite a common thing to meet with a universally adherent pericardium in the post-mortem room in a case in which the heart has been supposed to be healthy." Again, Sir William Gairdner says, "A certainly-not-small proportion of persons affected with pericarditis and its sequelæ, adhesions, may survive the attack for many years, living in tolerable comfort, without the inconvenience attending upon a dilated or hypertrophied heart." Lastly, I think this reference will interest you; it is a summary of the matter, made by Dr. Sequirà: "It has long been a matter of surprise that the two layers of pericardium may be completely adherent without any evidence during life of interference with the cardio-vascular mechanism. It is quite a common thing to meet with a universally adherent pericardium in the post-mortem room in a case in which the heart was supposed to be healthy. Probably the most remarkable instance of this condition is a heart in the museum of the University of Edinburgh. The pericardium is universally adherent, and there is so great a deposit of calcareous material, that, except for about one cubic inch over the apex of the cardiac envelope, the envelope is as firm as the skull."

It has also been observed that in the cases in which adhesions are very firm there may be no hypertrophy. The point is an important one, because it shows that the presence of tough adhesions does not induce hypertrophy by resisting the contractions of the heart. I will come back to that directly. So we do learn that adhesions by themselves do not cause dilatation and hypertrophy. It is important for you to remember that, because some people have taught that the adhesions drag the heart out in some obscure way, and so lead to the hypertrophy. So far from this being the case, you often find evidence in the post-mortem room that the heart can tear away the adhesions. For instance, look at the long ones in the specimens here, which are stretched and some are torn; and I have seen adhesions sometimes an inch long between the visceral and parietal layers of the pericardium. This specimen in which they are so long, is the heart from a patient who was in the hospital as long ago as 1827; and here is another specimen I have brought down because it is from a patient of mine, and it shows the very long tags which have got torn by the contractions of the heart. You have to remember that dilatation is due to the fact that the heart is no longer supported by the inflamed pericardium, and therefore you do not find the dilatation unless the outer fibrous coat is softened.

Now we come to our second group; those in which adherent pericardium is of serious clinical importance owing to the cardiac symptoms. There are two subdivisions of that group. There is the comparatively rare group in which the exuded material of pericarditis becoming fibrous, contracts and clips the big vessels as they pass into the heart, and especially the veins. We need not stop to consider that group now, as it is very rare. It was described by Sir Samuel Wilks in the "Guy's Hospital Reports," in the year 1871. Then we come to the common group in which pericardial adhesions cause difficulty because the adhesions take place when the organ is dilated. And even in these cases a further trouble is, that the heart is often held out by adhesions on the outside to the pleura. What happens in these cases is, that the heart being dilated, the auriculo-ventricular orifice is dilated too, and the patient gets mitral regurgitation. He then gets bronchitis and œdema of the lung, and that proceeds to brown induration. And then there may be pleural and peritoneal effusion, nutmeg liver, hard kidneys, œdema and lividity—in fact, the case presents itself to you entirely as one of mitral disease. So much is

that true that it is a very good clinical maxim that if you have a patient who apparently is suffering from mitral regurgitation, but who is not benefited by digitalis and rest in bed, it is a fair clinical inference that he may be suffering from an adherent pericardium. Nature, however, does not entirely give up the struggle in these cases. Supposing there is some dilatation when adhesions take place, compensation is attempted, as I pointed out just now, by hypertrophying the heart. But, as I said, inasmuch as the work the ventricle has to do rapidly increases with the dilatation, if the dilatation is great, the hypertrophy cannot compensate for the dilatation. But if there is only a little dilatation, then the hypertrophy can compensate for it, and that is what I think has occurred in the man who was here just now. He really only suffers from dyspnœa. He comes into the hospital, rests a bit, goes out again and follows his work as a clerk in an office all day. There are no signs that his heart is so dilated that it is failing to compensate, there is no lividity or œdema, and in fact, as far as we can hope in such a case, the heart is hypertrophied and compensated. No doubt originally he had a little dilatation—his pericarditis occurred many years ago—but the heart hypertrophied enough to overcome that dilatation. So you see the second group is not altogether hopeless.

But do not think, from what I told you about the first group, that I want you to go away thinking that pericarditis so often results in adhesions with the heart of normal size that the disease does not much matter. It is a most serious disease, because not only does it often lead to dilatation, and the picture of an uncompensated heart with serious backward signs I have given you just now, but, unfortunately, pericarditis is much commoner in children than in adults, and in children the result is nearly always bad. There appear to be two reasons why in children pericarditis should be such a serious disease. One is, that the organ seems strangled, so to speak, by the adhesions, so that it cannot grow properly; and the other is that the pericarditis in children is very acute, so that there is a good deal of myocarditis, and the fibrous pericardium becomes very soft and sodden. Do remember that there are few things more serious than acute pericarditis, in children especially, and a great many of them become permanent invalids. But in adults also, unless the heart is normal in size, or so little dilated that it can sufficiently hypertrophy, the outcome is likely to be very serious. Therefore, it is of great importance, when you have a patient with acute pericarditis, to think how you can possibly prevent the heart from dilating, because if the heart remains dilated long, certainly the pericardium will become adherent when it is dilated, and then the patient is a permanent invalid whom nothing can cure. So I always tell you, and in that you will agree with me, that there is nothing more important than the treatment of acute pericarditis, because if you can get the adhesions to take place in an adult when the heart is of normal size they will not be of much importance. If you are looking after a man with pericarditis, obviously you must not raise his blood-pressure, because if you do the heart tends to dilate owing to myocarditis and sodden pericardium. Therefore, you keep him at rest on his back; you will not allow him to sit up. If you want to examine his back you roll him over; and you will not allow him to get out of bed for any reason whatever, because even slight muscular exertion, when one is ill, raises the blood-pressure seriously. Again, defæcation and vomiting both raise the blood-pressure considerably; so it is important, in pericarditis, to keep the bowels loosely open so that there shall be no straining. The patient must never have any medicine which makes him sick; if there is the slightest suspicion that digitalis makes him feel sick when given by the mouth, give it only by the rectum. You need to avoid over-distending the stomach, which would make the patient flatulent and push the heart up and so increase its work; so give him small feeds at frequent intervals. There is no disease in which sleep is more precious, because during sleep the blood pressure is lowered and the heart is slowed; and therefore the person with acute pericarditis is generally better for an injection of morphia at night to make him sleep. You would never think of giving alcohol, because it raises the

blood-pressure. On the other hand, digitalis is a valuable drug. In the first place, you want to contract up the heart, and digitalis will do that. I have told you that the work of the heart increases as the organ is dilated. Another advantage of contracting up the heart, as I have constantly pointed out to you, is that you want to get adhesions to form on the contracted heart. Again, digitalis prolongs the diastole. Repair of the heart muscle takes place during diastole, so the longer the diastole is, the longer the period for repair. And you know blood flows into the coronary arteries during diastole, and when the heart is diseased a good blood-flow is wanted through it. And so in every way digitalis is a good drug for acute pericarditis, if it does not make the patient sick. Morphia is the second best, because it gives sleep.

Another very important matter is to prolong the treatment, because it is a long while before the thick fibrous pericardium gets again strong enough to support the heart.

To conclude, I must mention our third group which is rare, and in which the patient is very ill; he is waterlogged, he has ascites, and great œdema of his legs. These symptoms continue for some time, and at the *post-mortem* it is discovered that the patient has universal pleural adhesions, universal pericardial adhesions, and universal peritoneal adhesions. A certain number of these cases are due to chronic tubercle, but a certain number are not. And, usually speaking, what strikes the makers of post-mortems most is the peritoneal trouble, for the capsule of the liver becomes so thick that the case is usually described as one of perihepatitis, or the sugar-coated liver of the Germans. It is not a very common disease, but it has been well-known to us here for many years. Dr. Fagge alludes to it, Dr. Taylor gave a lecture on it some time ago, and other members of the Staff have recorded cases. It forms quite a different clinical picture from the other groups, and I have only inserted it in this lecture to make it complete. The disease has been called Progressive Hyaloserositis, and any patient I am sure will be cheered, however ill he may be, when he realizes that his disease bears such a name as that.

Diagnostic Doubts.

If, as is averred by a great French savant, the greatest of all cunning is to seem blind to the snares which we know to be laid for us, then there walked round a female surgical ward a month ago a dozen of the most cunning diagnosticians Guy's has ever known.

Here are two cases, for ever establishing the professional acumen of these modern Hunters.

A married woman of 35 with a first-class family history, experienced, nine months ago, slight pains shooting from the shoulder to the nipple of the left side. She found a small lump the size of a cherry-stone to which she attributed this symptom. She observed it closely for some time, and noticed that it increased in size with each menstrual period, at the same time becoming rather more painful, while it usually decreased in extent after the period ended.

When the mass reached the size of a hazel nut the patient sought advice at the hands of the taking-in surgeon. Her condition was then as follows:—

General condition rather poor, as usual with her. A firm elastic mass the size of a cherry and the same shape, was found over the border of the pectoralis major and in the breast tissue. It was slightly above the height of the corset and had not been rubbed. There was very little tenderness, no adhesion to muscle or skin, and no retraction of, nor discharge from, the nipple. There were no enlarged glands in the axilla, and pain was absent at the time.

A diagnosis of fibro-adenoma was suggested by the ward-clerk in an assured but blasé tone, and after the exhibition of conclusive arguments by the "finalists," and of lamentable ignorance by the fatalists, the opinion found many adherents. Indeed, they so cunningly hid their knowledge of the true diagnosis, that they successfully feigned intense surprise when told that the section of the excised lump showed the structure of spheroidal-celled carcinoma.

With intellects dimmed by insidious reflections on their own mental triumph, they sauntered on in search of further conquest. Passing along the same ward they advanced upon a patient, whose reception of them would have abashed any but the keenest scientist. With the assistance of a report, which some day *The Times* will sell in twenty-four parts, and found a competition (probably for spelling) upon, these confirmed theorists elicited the following facts.

Patient, a married woman of 36, with three healthy children, was admitted for a swelling in the breast. Her mother died of cancer of the jaw, but until sixteen months ago this woman never suffered in any way. About that time she felt a small lump like a pea in the left breast close to the nipple. She does not know what caused it. There was no history of a blow or sore nipple. Her youngest child is six years old.

The mass gave her no inconvenience until three months ago, when she very frequently felt a dragging pain about the region of the nipple. She noticed that the lump had

increased slightly in size, but, she thought the increase had been gradual. It appeared to occur chiefly during her menstrual periods. When the pain commenced, she had a slight milky discharge from both nipples, which has recurred once or twice.

On examination, there was on the outer side and below the nipple of the left breast, a flat oval mass, fairly hard, very nodular, easily movable, and the size of half a walnut. There was no induration of the breast tissue around it, no retraction of the nipple, nor adhesions to the skin. No discharge could be pressed from the nipple. Above, and to the outer side, was a smaller but similar mass, and on the periphery of the same breast there was a small nodule firm and movable. While in both axillæ there were one or two soft, but enlarged, glands.

Here was a chance. The first offer came from a surgeon of few years, but undoubted blood. His knowledge of surgery was looked upon as an extra sense. The only foundation for that view of his merits, as far as we know, is, that it is perfectly certain he never gathered any knowledge from anyone else. He put forward "carcinoma" as an opinion that should be final. His vis-à-vis, a goggled bookworm, thought the diagnosis rested between eight things; he rather inclined to five of them as providing a solution. The majority of these noble fellows came to the conclusion that "interstitial mastitis" would meet the case. There were few dissentients. An incision was made on the following day, and disclosed a tumour which represented the two felt near the nipple —two masses joined by a narrow bridge of firm tissue.— On opening, they saw several small cavities containing pus, and numerous small white specks with the appearance of tubercles. The rabid "London" man, who was known to have "backed" himself for the whole of the "colleges" final, told all his colleagues how he had thought of that the day before and was not in the least surprised. What was their surprise on hearing the section showed "spheroidal-celled carcinoma"? And what was ours compared to the surprise of the man of blood?

Papers by Guy's Men.

The Correction of Hereditary Tendencies. By Sir Samuel Wilks, Bart., M.D. Lond., F.R.S., LL.D. Edin.—*Lancet*, 24th October.

Some cases of the Dilatation of the Bronchial Tubes after Measles. By Theodore Fisher, M.D., M.R.C.P. Lond.—*Lancet*, 31st October.

Four cases in which a Cystic Ovarian Tumour, which was not Malignant, developed after a similar growth of the Ovary on the same side had been removed. By John D. Malcolm, M.B., C.M., F.R.C.S. Edin.—*Ibid.*

A Lecture on the Mental Diseases of the Climateric. By George H. Savage, M.D., F.R.C.P. Lond.- *Ibid.*

Phthisis in Relation to Life Assurance. By T. D. Lister, M.D., M.R.C.P. Lond.—The *Practitioner* for November, 1903.

In Lighter Vein.

SPECIAL NOTICES.

"And he bade his trumpeter sound."—TENNYSON.

"Mr. James Marr Brydone, M.B., B.C. Camb., of 42, Welbeck Street, Cavendish Square, W., writes to say that he is not connected or acquainted with the Dr. Adam Brydon mentioned as a party in the Divorce Court proceedings on Thursday last."—(*Vide* Daily Paper, November 2nd.)

Mr. Milson, of the "Ship and Shovel," desires it to be known that he is not acquainted with any other gentleman whose name resembles his own.

Mr. James Marr Brydône, M.B., B.C. Camb., late Medical Resident in Bright Ward, Guy's Hospital, now of 42, Welbeck Street, Cavendish Square, W., writes to say that he is not connected or acquainted with the Dr. Adam Brydon mentioned as a party in the Divorce Court proceedings on Thursday last.

Dr. French, of Newcomen Street, begs to state that he is not connected, nor has he any desire to be acquainted, with any other practitioner of the same name.

Mr. James Marr Brydône, M.B., B.C. Cantab., of 42, Welbeck Street, Cavendish Square, W., late Editor of GUY'S HOSPITAL GAZETTE, begs to state that he is in no way connected with Dr. Adam Brydon mentioned as a party in the Divorce Court proceedings on Thursday last.

Dr. Thompson, of Sheffield, desires it to be known that he strongly objects to being either connected or acquainted with Mr. Brydône, M.A., B.C. Camb., of 42, Welbeck Street, Cavendish Square, W.

Mr. James Marr Brydône, M.A., B.C. Camb., of 42, Welbeck Street, Cavendish Square, W., writes to say that he is neither connected or acquainted with Dr. Adam Brydon mentioned as a party in the Divorce Court proceedings on Thursday last.

—From our special correspondent

"PUFF-PUFF."

Notices.

THE GULL STUDENTSHIP.

THE GULL STUDENTSHIP IN PATHOLOGY and allied subjects will become vacant on the 31st December next. The Studentship is open to candidates under thirty years of age, who have studied in the Medical School of Guy's Hospital, is about the annual value of £150, and is tenable for three years. Further particulars may be obtained from the Secretary of the Board of Electors, to whom application must be addressed at the office of the Medical School not later than Wednesday, December 22nd, 1903.

UNIVERSITY INTELLIGENCE.

A Course of Eight Lectures on "The Fossil Reptiles of South Africa," will be given in the Geological Laboratory, King's College, Strand, W.C., by Professor H. G. Seeley, F.R.S. (Professor of Geology in King's College), on alternate Tuesdays during Term-time, from November, 1903, to February, 1904, at 4.30 p.m.

1. November 3rd, 1903. History of their Discovery.
2. November 17th. Relation of these Animals with Lower Types of Life.
3. December 1st. Resemblances to the Lower Mammalia.
4. December 15th. Diversity of these Fossil Animals in Organization.
5. January 12th, 1904. Approximations to Other Extinct Reptilia.
6. January 26th. The Pariasaurians and Allied Animals.
7. February 9th. The Dicynodonts and Allied Animals.
8. February 23rd. The Theriodonts, their Dentition and Associated Structures.

The Lectures are addressed to advanced Students of the University, and others interested in Zoology and Palæontology, and to persons specially interested in the South African Colonies.

There is no Fee for the Course; cards of admission may be obtained on application to—

P. J. HARTOG, Academic Registrar.

EXAMINING BOARD IN ENGLAND BY THE ROYAL COLLEGE OF PHYSICIANS OF LONDON AND THE ROYAL COLLEGE OF SURGEONS OF ENGLAND.

The following are the dates on which the Examinations will commence in the year 1904.

FIRST EXAMINATION.

**Chemistry*.—Tuesdays, January 5th, March 29th, July 26th, September 27th.

Biology.—Tuesdays, January 5th, March 29th, July 26th, September 27th.

Practical Pharmacy.—Wednesdays, January 6th, March 30th, July 27th, September 28th.

SECOND EXAMINATION.

Physiology.—Thursday, January 7th. Wednesday, March 30th. Thursdays, June 30th, October 6th.

Anatomy.—Friday, January 8th. Thursday, March 31st. Fridays, July 1st, October 7th.

THIRD OR FINAL EXAMINATION.

†*Medicine* (1st Paper).—Tuesdays, January 12th, April 5th, July 5th, October 11th.

Medicine (2nd Paper).—Wednesdays, January 13th, April 6th, July 6th, October 12th.

Midwifery.—Thursdays, January 14th, April 7th, July 7th, October 13th.

Surgery.—Fridays, January 15th, April 8th, July 8th, October 14th.

* The Examination in Practical Chemistry will be held on Friday, January 8th, Saturday, April 2nd, Fridays, July 29th, October 7th.

† Candidates who registered as Medical Students before the 1st January, 1892, are not required to sit for the First Paper in Medicine.

The First Examination (Part I. Chemistry and Part III. Elementary Biology) will be held in Manchester as well as in London, provided there are at least ten Candidates in each subject. Candidates should state when sending in their applications whether they desire to be examined in Manchester or in London.

Candidates intending to present themselves for Examination are required to give notice in writing to the Secretary of the Examining Board in England, Examination Hall, Victoria Embankment, London, W.C., *fourteen clear days before the day on which the Examination commences*, transmitting at the same time the required Certificates.

All Candidates are required to produce Certificates of Age when entering for the first time for any part of the Final Examination.

All Fees must be paid not less than three days prior to the day on which the Examination commences.

Synopses indicating the range of Subjects in the Examinations in Chemistry, including Chemical Physics, Practical Pharmacy, Elementary Biology, Physiology, Forensic Medicine, and Public Health may be obtained together with the Regulations.

University Candidates are reminded that they should send with the Schedule of Certificates when applying for admission to the Final Examination, a certificate from the Registrar or other official of the University showing that they have passed Examinations in the subjects of the earlier Examinations of the Board.

N.B.—Books of Questions set at the several Examinations of the Board for each year from 1887 to 1903, may be had on application to Messrs. Taylor & Francis, Printers, Red Lion Court, Fleet Street, London, E.C. Price 6d. each, Post-free 6½d.

FREDERIC G. HALLETT, Secretary.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Physical Society.

DEAR SIR,—I regret to think that the Physical Society, having for its honorary president a distinguished member of the consulting staff, should be the least flourishing of all the societies connected with this hospital.

Perhaps the Blue Book would give many the impression that this society, from the number of its officials, is in a most prosperous state. But when I correctly say that the attendance at ordinary meetings, excluding the officials, can sometimes be counted on the fingers of one hand, I always think that even the Blue Book itself should blush!

The natural question to ask is, Where lies the fault? I consider it can be found when one glances over the programme for this session (which, by the way, is much the same as those of the last few sessions) and finds such subjects as "Blood Counts" and "Treatment of Fractures," on the list. Are not these subjects well thrashed out in both medical and surgical wards respectively? We must remember that the environments have altered much of late years. Now we have a number of clinical lectures delivered and printed on such subjects. But I care not to find fault unless I can suggest an alternative.

Would it not be more interesting and more instructive, as I heard a popular member of the surgical staff suggest, to invite old Guy's men—who, I feel certain, would willingly come—who are well known general practitioners either in or around London, to deliver a lecture, or series of lectures, on the difference between Hospital Practice and General Practice. A subject which is all important, but on which we hear next to nothing.

Then, I venture to say, we should not find young practitioners called to book so often by their elders.

I am convinced that, not only would the Physical Society flourish if this plan were adopted, but it would confer upon men that knowledge that we so sadly need.—I am, etc.,

W. COLLINS LEWIS.

An Appeal.

SIR,—I have been asked on behalf of the Bishop of Zanzibar (The Right Rev. J. E. Hine, M.D.), to make known the great need that exists in his Diocese for the services of a fully qualified medical practitioner.

In a letter received within the last few weeks the Bishop writes:—

> "After completing a visit of some duration in the Magila Archdeaconry, I see more clearly than before what an opening there is here for a doctor, and what a useful work he could do in this part of the country. Wherever I go, whether to Msalabani, or Kologwe, or into the interior, I have people coming to me seeking medical or surgical treatment, genuine cases often of considerable scientific interest.
>
> "At Kologwe, in this last week, I had to do quite a succession of operations, and there were other cases needing longer and more careful attention, which I could not, owing to lack of time, undertake with any hope of benefit to them. A resident surgeon (resident in the district I mean) would have now a considerably larger area to travel over than was the case some years ago when Dr. Ley was alive. The people all prefer to come for treatment to the Mission or to the Mission Dispensaries, rather than go to the German Government Hospital at Tanga, excellent though it no doubt is. With our present staff of nurses there ought to be no difficulty in a competent man undertaking cases of the gravest nature. In the Likoma Diocese I had the valuable help of Dr. Howard (of Guy's Hospital), and his work, I hear, is always increasing, as the people on the lake shores got to understand and to value the skilled treatment they receive at his hands. We want another Dr. Howard here at Magila; he would find plenty to do, and possibly a good deal to investigate of scientific interest, as well as very practically helping the work of the Mission. Such a doctor must, of course, be one in thorough sympathy with the Church work that is carried on in the country, and he should have to some degree the missionary vocation himself, though he would not be required to do anything else except to pursue his own particular calling.
>
> "There is also the health of the European staff to be considered; that too requires a resident doctor, so that in severe cases it may not again be necessary to cable to Zanzibar for assistance, or to send down to Tanga on the possible chance of being able to call in the German doctor who is sometimes to be found there.
>
> "If those, who are in touch with hospitals or with young surgeons recently qualified, could bring this want before them, it is not unlikely that someone might be found who would be willing to offer himself for the work."

I should be most glad to give further and more detailed information to any who may desire it.

OSWALD A. BROWN, M.D.
Member of the Medical Board o the Universities' Mission to Central Africa.

Reply—
c/o Secretary,
Universities' Mission to Central Africa,
9, Dartmouth Street,
Westminster, S.W.

25th October, 1903.

Passim.

THE changes shortly to be made in the Front Surgery and its immediate vicinity, are more extensive than many of us have at present been led to expect. In addition to the two Women's dressing-rooms to be built out into the east court of the Surgical buildings, there are many alterations to be made in the rooms as they now stand. In the Men's surgery the "dark room" is to be done away with, and the wall hitherto bounding the left side of the passage leading to the Dressers' room and the "Women's" will be practically in a line with the fireplace; this change, together with the removal of sister's room to the "Women's," will make a very appreciable difference in the size of the "Men's." The Dressers' room is to be transformed into a waiting room for women, the wall between it and the apartment that up till now has been a convenient storehouse for the "Take-in" Dresser, is to disappear, while this latter room is to be converted into a Women's dressing-room. In the women's surgery the fireplace is to be blocked out, and the row of forms will extend up nearly to the door of the skiagraph room.

THE Dressers' room is to be moved to the first floor, where at present are the bedrooms of the A.-H.-S. and the "Take-in" Dresser. This is a situation that has many obvious disadvantages, compared with that of the present room; but we venture to think that on the whole the new quarters will be a great improvement, and for many reasons. Not only will they be better aired and better lighted, but the hospitality of the dresser will be less taken for granted by those gentlemen of easy conscience, who do not consider non-acquaintance with a host any bar to their partaking of his salt uninvited. We would warn these gentlemen of the stairs that will in future be interposed between them and their prey.

IT is with awe and wonder that we hear on high authority that "the faculty" is offended with that excellent play, "Little Mary," now being produced with so much success at Wyndham's Theatre. Certainly, when we made our descent upon the golden west, and saw this, Mr. Barrie's latest, delightful satire, it was obvious to us that the medical profession suffered severely at the hands of the playwright and his excellent interpreters. But surely our profession is not to be the only one unexploited by the actor. Upon the stage, the curate has come in for perhaps more than his fair share of ridicule, the lawyer is a villain of the deepest dye, the artist is impossibly Bohemian, the soldier is relegated to melodrama, where he reigns the people's darling—but the doctor hitherto has been left unmolested; and if in his capacity of healer of the mystic brain fever (beloved of the dramatist as well as of the author) he has trod the boards, then he has always been, humanly speaking, colourless enough as an individual to win the approbation of even "the faculty." But with Mr. Barrie and his accomplices "the faculty" is offended —deeply so! Our only comment is that that is what we should have expected of a body of men who can sit still under so infamous a title as "the faculty."

THE journalist has also been tilting on the same errand as the playwright. In a well-known and highly respectable daily paper a wicked rhyme lately appeared, to the effect that a certain surgeon's worst fears were realised when he discovered one fine day a "nest of cocci" in his beard. In discussing so libellous a suggestion, we not unnaturally feel that we are treading upon thin ice. But the few beards there are amongst us are trimmed —that is to say nearly all of them—and we feel sure, that in any case it was no surgeon in particular that this sinful ditty referred to.

NOWADAYS nothing is sacred! In another column will be found a letter from a correspondent, who asserts that even the Physical Society is not all that it should be. Perhaps the commencement of a new session is hardly a fitting time to criticize the Society, and the remarks as to the attendance of its meetings, at present certainly lack foundation in fact. But the suggestions made by the writer of the letter would seem to be well worthy of the attention

of the responsible officials. The fact that the system of education in this hospital is to come under discussion later in the session, shows that it is not intended to unduly limit the scope of the Society's programme by a too great insistence on its title "Physical." In any case, we feel sure that suggestions of any sort will not be spurned by the secretaries and presidents, who are not hide-bound pedants, and if the proposal as to lectures on general practice is a feasible one, then it may reasonably be expected that the suggestion of our correspondent will be adopted.

THE next meeting of the Physical Society is to take place this evening, November 7th, in the Smoking Room of the Students' Club, when Mr. G. Russell will read a paper on "The use and limitation of blood counting." The chair will be taken at 8 o'clock by Mr. P. R. Bolus.

A GUY'S HOSPITAL Series of six picture post cards has just been published by Messrs. Ash & Co., Ltd., and the following are the views that have been selected as representative pictures of Guy's. First there is the Front Quadrangle, clear of the officious scaffolding that was an eyesore for so long. The Nurses' Home from the corner of Clinical, also makes an excellent picture, while two interiors—of a medical and a surgical ward respectively—leave nothing to be desired. The greater part of the body of the Chapel, taken from the back gallery, is a picture that will interest many, while that long stony vista, down which Commissionaire has for so long gazed in varying moods, is a view of the Hospital which must appeal to all. For the modest sum of sixpence can this excellent set of photographs be secured, and when it is added that the proceeds are to go towards meeting the general expenses of the Hospital, we feel sure that the demand will be great. Orders can be booked with the Librarian, the Secretary to the Treasurer, at the Matron's Office, or with the Publishers.

WE are in possession of an advance copy of a short illustrated history of the Hospital, published to-day by Messrs. Ash & Co., Ltd., entitled "Guy's Hospital, 1724–1902, a tribute to its founder and a record of its work." This book, which is paper bound and has a most artistic design upon the cover, should have a wide sale amongst Guy's men and all those who are in any way interested in this Hospital and its work. The illustrations, which are in warm colour and form an excellent contrast to the type, are in many cases most excellent pictures, and the whole is calculated to create a much livelier interest in the inner workings of this many-sided institution. There are of course other and more extensive sources of information on this subject, but we venture the opinion that this, being a small and compact work, will not only answer the demands of all ordinary enquirers, but will supply the needed information in a novel and interesting way. The price of the book is half-a-crown, or by post two-and-ninepence. The profits on the sale will be devoted to the hospital funds. Orders may be sent to the Secretary to the Treasurer, or to the Publishers.

WE take this opportunity of announcing that a special advance course in Bacteriology and Parasitology will be conducted by Dr. Eyre during the first three months of 1904. The course will embrace the work required for the Final M.B., D.P.H., and London M.D. in State Medicine, and the classes, to be held on Tuesdays and Fridays from 2.30 till 5, will consist of practical work in the lower laboratories till 4 o'clock, when a lecture with lantern slides will be delivered, probably in the Physical Theatre. Another special course in Bacteriology, of a more elementary nature, will extend over November and December of this year. This latter is to be for students other than those of this hospital, and will only be held if a sufficient number of men signify their desire to attend the same.

ALL will remember the most successful Sale of Work and Garden Fête that was held in June last at the Nurses' Recreation Ground, in aid of the Guy's Hospital Children's Home. We are informed that a supplementary sale, in aid of the same institution, is to take place on Thursday, November 26th. Unfortunately, the long, dark, dreary winter is upon us, and there

is thus no possibility of again utilising the sylvan environment which so greatly enhanced the excellent work done in the summer. But, by the kindness of the Governors, the Court Room has been lent for the occasion, and it is there that this sale will be held, between the hours of 4 and 6 p.m. on the date named. Admission, we are told, is to be free, and—most important is this last—tea will be obtainable. It is to be hoped that all who are interested in this excellent institution will make a great effort to be present, that this venture may be as great a success as was the earlier one.

We would call attention again to the Chapel Choir, the anniversary of whose inception is to be celebrated to-morrow, November 8th. The choir is probably a unique one in being composed entirely of the medical element, and by the energy of the choirmaster, in working what a year ago was raw material, the services have been rendered both hearty and impressive. This is therefore a most fitting occasion to again emphasize the need there is for active support from freshmen, and from all those whose interest hitherto in this excellent institution has not been sufficiently roused.

A wail has reached us concerning the uncatalogued state of the Surgical Museum, and the difficulty of identifying specimens for want of a sufficiently descriptive label. Certainly the chaos of this museum affords a striking contrast to the apple-pie order and neatness of the medical specimens, and those who groan in spirit over the former puzzles will be glad to hear that a movement is on foot to procure the same transformation in these, as has latterly taken place in the Medical Museum. It is to be hoped that the present generation of Guy's men will benefit by this proposed improvement, and that we are not simply rejoicing like the patriarch in the prophetic sight of a fortunate descendant's day.

There are many hockey players in our midst, both senior and junior men, and it is a pity that they should be tempted to swerve in their allegiance to this game, owing to the non-existence of a hospital team and a ground for that team to play upon. We are in a position to state, that negotiations for the purchase of a ground are at present taking place, and are expected shortly to be completed; so that there may soon be a Guy's Hospital Hockey Club established, which, it is hoped, will be a welcome and successful constituent institution of the Clubs' Union.

We are now in a position to discuss the prospects of the 1st XV., who are to uphold the great reputation already won for Guy's in the Rugby Field, and to see that the Cup shall remain with us for yet another year. There was considerable curiosity on the occasion of the trial matches, as to what sort of show the new men would make, and the general verdict was decidedly favourable. The new forwards are keen, and while they cannot at present be expected to show the form of last year's men, they at any rate promise in time to adequately fill the gaps left by the latter. That the commencement of the season should have been marked by two defeats, at Catford and Cambridge respectively, is perhaps not altogether to be lamented, as these should serve as wholesome reminders that previous successes have not been easily won, but only after hard fighting, and with the necessary accompaniment—hard knocks.

Not the least happy feature of the present football season from the point of view of the Clubs' Union, is the success that has already met the efforts of the authorities over their institution of a gate fee at the Honor Oak ground. On the first day of this innovation, in spite of the fact that other first class teams beside our own were playing in London and the suburbs—the gate was considerably over six hundred. This is a most encouraging state of affairs, and, it is believed, but a foretaste of what is to come. The management of the gate, together with the advertisement of matches, is in most excellent hands, and if as large a gate as six hundred can be taken thus early when counter attractions are great, we feel sure that the enterprising powers-that-be will not rest until the numbers have crept well into the palmy region of four figures. There is little need, perhaps, to emphasize the fact, that with this innovation it should be looked to that the reports of matches, hitherto somewhat curtailed in the sporting papers, may occupy as prominent a place as those of other teams whose gates are, like ours, conducted on business principles.

Obituary.

W. E. Image, F.R.C.S., L.S.A.

Mr. W. E. Image, who passed away on September 26th, at Herringswell House, near Mildenhall, Suffolk, was perhaps not only the oldest Guy's man, but one of the oldest, if not the oldest, medical man in England. He was born in 1807, and as a student at Guy's Hospital was a contemporary of Cock. In 1821 he graduated at Paris as Bachelier ès Lettres. In 1830 he became a Licentiate of the Society of Apothecaries, and in the following year a member of the Royal College of Surgeons, of which body he was elected a Fellow in 1844. Settling in Bury St. Edmonds, he built up for himself a great reputation, not only for his skill and kindliness as a medical man, but also for the valuable evidence he gave at several cases of arsenical poisoning, which was exceedingly rife at the time in East Anglia. From these, and owing to the great interest he took in toxicology, he sprang into wide repute. In 1873 he retired from medical practice, but played a considerable part in public affairs. He was Justice of the Peace for Suffolk and Deputy-Lieutenant, and in 1887–1888 was High Sheriff of the County. To the day of his death he was a Fellow of the Royal Medical and Chirurgical Society.

Pupils' Physical Society.

THE First Meeting of the Society, held in the Wills Library, took place on Saturday, October 24th, under the chairmanship of Mr. C. H. Robertson.

The occasion was a Clinical Evening, and the new Library proved to be admirably adapted for such meetings, the patients being placed separately in the divisions between the bookcases, and there examined, while the subsequent discussion took place in the large space at the end of the Library on the left. The Society is indebted to the honorary librarian, Dr. Shaw, and to the Dean, for permission to use these new and comfortable quarters for its Clinical and Pathological meetings. Now that the electric light is finished and the new chairs have come, no more luxurious meeting place could be desired. There was a good attendance.

The following cases were shown:—

Periosteal Sarcoma of the Humerus.	Mr. McAlister.
Osteitis Deformans, two cases.	The Chairman.
Chancre of the Tongue.	Mr. G. A. Ticehurst.
Case of a Premaxillary Tooth appearing externally after Operation for Hare-lip.	Mr. Fawssett.
Habit Spasm.	Mr. Milsom.

An excellent and critical discussion took place upon each of the cases, in which, besides the exhibitors, the following members took part:—Messrs. Wallace, Bowen, Black, R. Thompson, Glanville, N. I. Spriggs, Reinhold and Milsom.

Coffee was served shortly before 10 o'clock.

Guy's Hospital Debating Society.

"Confound their politics."—*National Anthem.*
"There were noblemen in coronets."—*Bab Ballad.*
"I've been there once and only once."
"Never! Ah! Never again!"—*Old English Song.*

On Saturday, October 17th, the Debating Society held its opening meeting for this session. The President, Dr. Savage, took the chair at 8 o'clock, and the proceedings throughout were of a most exciting and interesting character. Besides mere mortals, there were present:—

The Monarch of the Mastoids.
The President of the Residents, smiling an inimitable baritone smile.
The Count of the Cephalotribes.
The Lord Warden of the Baths (two of 'em, *pro tem.*)
The Earl of Eyeballs.
Mr. Philip Turner, who made several attempts at singing, "Down among the dead men."
Chevalier Wrench *sans reproche* in dark serge.
Mr. Rudeolph Thompson, who was compelled to sit with his back to the President, as his head had been turned by the Scotch ladies.
Mr. Ernest Harrison Griffin, present in spirit.
Mrs. Black—the only lady—who was admitted at the last moment, on her assuring the Beautiful, Bountiful Boniface that she was "old enough to be the prezzident's mothar!"

Amongst others there were absent:—

The Lord Protector of the Pros. (?), and
Mr. Ernest Harrison Griffin (in body).

The evening began with two more-than-usually-futile attacks on the impeccable secretaries. One antique old thing—Mr. PERCY BOLUS to wit, clad for once in a sombre fashion, ventured to remark on a tendency to levity noticeable in the reports of debate, which appeared in the GAZETTE during the Society's last session. However, this gentleman realised his mistake the minute he had ended his monotonous cavillings, for the House rose to a man to denounce him, and it was with the greatest difficulty that order was secured, and a vote of utter confidence in the secretaries passed, this same vote being proposed by Mrs. Black, seconded by Master Muffin, and carried unanimously by the whole House.

(The secretaries beg that there may be no more of this nonsense.)

The other disturber of the peace was Mr. L. J. J. ORPEN, a person of Dutch extraction, who so far forgot himself as to cast reflections on the domestic life of the senior secretary. He was not permitted to continue his revolting and unmanly attack. Loud exclamations of disapproval and dissent were heard on all sides, and upon the President's timely and tactful assertion of his authority, this wretched man was led back to his seat, beside the genial President of the Residents, where he resumed that attitude of playful opisthotonos so essentially his own.

(We learn on high authority that the person Orpen, for this and a subsequent disgraceful exhibition, was later in the evening delivered over to the tormentors in the persons of the then firm attached to Mr. R. Clement Lucas, Senior Surgeon of this Hospital, at whose hands he suffered grievously, being "cut" and "scraped" on his left arm, to expiate the foul slanders uttered by his tongue, and other grievous deeds done in the body.)

The President now called upon Mr. P. Bolus to propose, "That this House has no confidence in the present Government and considers it imperative that they resign immediately."

Mr. BOLUS, who was greeted with loud and ironical cheers from both sides of the House, began by saying that he had no intention of dealing with details. (Cheers and laughter.) There could be no doubt that orchids were England's most important import. Had any member of the House ever seen an orchid at any time. (Cries of No, No). How was it then that the most important article brought into this country never found its way to the lower classes. (Tumult, and cries of, "What about yourself?") It was his (P.R.B.'s) firm belief that these orchids, intended as they were for the people, were being appropriated by influential members of the Cabinet. (Cries of "Shame.") What would the House say, then, when they heard that the very man, whom he most strongly suspected of this wilful appropriation of orchids, had suddenly left the Cabinet (General consternation) and no measures had yet been taken to bring him back. (Panic.) It was a deliberate winking and conniving at guilt on the part of the Ministry, and a course of action which should result in the violent ejection from office of so corrupt a posse of persons. (Chaos, loud cheers and cries of "Well done.") Before he resumed his seat his love of physiology compelled him to tell the House a story about a donkey. (We cannot give details, they would disgust our readers.) This having been accomplished, Mr. P. Bolus resumed his seat, which in the opinion of the House had been left vacant far too long.

The President next called upon Mr. Harold Mann to oppose the motion, and that gentleman, who has recently been elected an honorary member of the Guild of the Rimhi's, rose to his feet, and speaking in an impassioned treble, endeavoured to weaken and to controvert all that the honourable proposer had said.

Mr. MANN was most anxious that his audience should not be in any doubt as to his identity. Mr. George Bernard Shaw had recently written a book upon "Man and Superman," but he hoped that in spite of his own commanding appearance they would not confound him with "Superman," he was simply Sonnyman and very much at their service. With flashing eyes he turned upon Mr. Bolus, who, he declared, was "So old and so untruthful." He could not have expected his opponent, as a physiologist, to have been particularly careful as to facts, but that he should have so perverted the few that he touched upon was to his deepest discredit. "I will give the House," said Mr. Mann, "a summary of the national expenditure in the year 200." Here he laughed a shrill, cracked laugh, which suddenly ended in a groan as the Mastoidon made a determined attempt to politzer him before he could get under way.

When once released from the Mastoidon's clutches by the timely aid of Chevalier Wrench, who was reclining close at hand, Mr. Mann plunged into a perfect sea of figures. At times the onlookers gave him up for lost, but yet again he rose, and with a gleeful chuckle emitted another financial fiction ere he once more sunk into the treacherous waters. And when exhausted and all but dead he emerged and dropped upon the opposition bench, then "e'en the ranks of P. R. B. could scarce forbear a cheer."

Upon the meeting being opened to general discussion, the first to arise was Mr. Collins Lewis, whose homely face, adorned as usual with gold-rimmed spectacles, was a signal for a fresh outburst of merriment.

Mr. LEWIS considered Mr. Bolus both exhaustive and exhausting. He counselled moderation in epithets and censured the love of highly coloured language, so rife amongst enemies of the Government. At the same time he added that the Government was going "devilward and mammonward." Bursting into a wild Celtic song, he appealed to the Mastoidon, who was still seated behind Mr. Mann, to:—

"Speak roughly to that little boy,
And smack him when he wheezes.
He only does it to annoy,
Because he knows it teases."

Mr. MYOTT, who followed, was very gentle, very tender and very yearning. He complained that in time, if this Government remained in office, he would not be able to buy buns, as his custom was. He spoke sorrowfully and at some length on the execution of a certain Mr. Barnacle.

Mr. WATNEY spoke in so cultivated a way upon the subject under discussion, that he succeeded in persuading both the House and himself that he knew what he was talking about.

Mrs. BLACK next arose and spoke in her customary crisp manner. She explained that it was not so much *what* she said, as the way she said it, that was of importance. But at the same time, if nobody understood her, she was perfectly willing to repeat herself.

Mr. DIGBY and Mr. STEBBING now followed respectively with most excellent speeches. If there are many speakers of the same calibre amongst the junior men the Society need have no fear for the future. Both speakers incidentally assured the House that at the next meeting the Medical School would be most strongly represented, as they could most certainly assure their fellows, that nowhere could a more pleasant evening be spent, than under the auspices of the Debating Society.

At this point it was moved by Mr. Mann, and seconded by Mr. Collins Lewis, that there might be a suspension of the 10 o'clock rule. This motion was carried unanimously, and all would have gone well had not Mr. Orpen seized his opportunity and created another disturbance

by declaring that England's greatest market was in herrings.

Mr. SNELL, who was extravagantly apologetic for addressing the President from so bathetic a rostrum as the bar counter, made a most excellent cross bar speech.

Mr. Mann and Mr. Bolus replied respectively.

On a division there voted :—

For the motion	...	...	...	25
Against	...	...	...	46

Motion lost by majority of 21 votes.

A hearty vote of thanks to Dr. Savage for occupying the chair, was proposed by Mr. Ormond and carried with acclamation, and a very successful evening was thus brought to a close.

Guy's Hospital Dental Society.

On Friday evening, October 23rd, the Dental Society held its opening meeting for this session. The attendance was exceedingly good, amounting to as many as seventy members. The introductory address delivered by the Society's President, Mr. W. A. Maggs, was listened to with the deepest attention, and its conclusion was marked by loud applause. Mr. Maggs in addressing the meeting spoke as follows :—

GENTLEMEN,—First I must acknowledge my keen appreciation of the honour you have conferred upon me in electing me your President for the second time, and I desire to thank you for your kindness, and to express the hope that the papers brought before the Society may prove instructive and promote discussion, and that the meetings during the session may be well attended. It having been suggested that an introductory address would interest the members of this Society I willingly accept the suggestion, and that without further apology.

Students' societies fulfil several useful purposes, to wit, they encourage men to read papers, to take special care and study over their preparations, to verify all quotations, and to be prepared for a frank and perhaps severe criticism should unreliable statements be made. It has been said, anyone can prepare and read a paper, but it takes a clever man to answer the questions which may ensue thereon. This may sometimes be correct, but it frequently happens that the questions asked touch only the fringe of the main subject, and at other times the discussion is allowed to drift far away from the intended scope of the paper. Nevertheless, discussions and criticism are valuable, as they lead to a higher appreciation of the subject brought before the members.

It is always a pleasure to listen to a good speaker, and facility of speech is mainly acquired by practice, and who knows what oratorical skill may lie hidden amongst those now sitting before me? Again, it is well to interchange ideas with others of the same vocation; indeed, we all owe something in this respect to the profession of our adoption, and dental students' societies are good training schools for the meetings of the Odontological Society, and of the British Dental Association, which meetings you may desire to attend in later years.

No doubt you all agree with me about the advantages of this Society, and you will best show your appreciation in a practical manner by your constant attendances, your eagerness in bringing forward papers and cases, and in joining in the discussions.

It is now eight years since I was first elected your President, and a brief retrospect of that period, coupled with some advice and encouragement to new students, may not be unprofitable as a prelude to the work of the session.

Turning our first thoughts to Guy's it is to be noted that a Biennial Dental Travelling Scholarship was founded in 1900 for the encouragement of post-graduate education in foreign schools. It was felt that the wider the experience of the scholar, the better fitted he would become to fulfil the position of a teacher at Guy's Dental School, should he be appointed as a Staff Demonstrator. As you are probably aware our first travelling scholar studied for nearly one year in the dental department of Philadelphia University, and the second is about to spend the coming winter at the School of Dentistry in Paris. It is hoped that our scholars will eventually gain experience from each of the principal dental schools throughout the world, and Guy's benefit thereby.

Guy's Entrance Scholarship in Arts for dental students, which existed up to the year 1900, was replaced in that year by one in Dental Mechanics, and later two scholarships in mechanics have been awarded annually, in May and September respectively. The change of scholarship from Arts to Mechanics was made in order to improve and stimulate the teaching of private laboratory work.

The highest skill of the student was formerly shown in the execution of interstitial and contour gold fillings, but it is now also shown in the insertion of porcelain inlays, the latter work having to a large extent superseded the former, both on account of its artistic appearance and the saving of time in the operation. The development of bacteriological science has led to greater success in conservative methods, particularly in the treatment of septic roots, and it has also taught us thoroughness in the sterilization of our instruments and hands. The Röntgen Rays, unknown to us a decade ago, have been in daily use for some years, and skiagrams materially help in the diagnosis of obscure fractures and swellings of the jaws.

It is possible that the X-Rays, the Finsen Light, and Radium, may at no distant date be utilized in the treatment of oral diseases.

New drugs have found recognized places in practice, and amongst those commonly used may be mentioned, *e.g.* :—As *Hæmostatics*, Adrenalin, the active principle of suprarenal glands. Calcium chloride, both internally and externally. *Antacid for Hyperacidity of Mouth.*—Milk of Magnesia, MgH_2O_2. *Antiseptics.*—Chinosol, Formaldehyde, Lysol.

Progress, too, has taken place in the domain of the anæsthetist. The administration of nitrous oxide gas with oxygen has come into more general use, and a much prolonged period of anæsthesia can now be produced by means of N_2O given through the nares.

Ethyl chloride, formerly used only locally, has been found to possess general anæsthetic properties, and is rapidly gaining favour in the hands of experts, in preference to the preparation called "Somnoform," consisting of ethyl chloride 60 parts, methyl chloride 35, and ethyl bromide 5.

Amongst local anæsthetics the most important addition is that of eucaine, alpha and beta, these two varieties being due to a different arrangement of the radicles in the molecule. Eucaine is said to be more stable and less toxic in effect than cocaine.

During the period under consideration the standard of the preliminary examination in arts for the dental and medical student has been raised. Now, is it not a curious coincidence that the number of registered dental students and practitioners has decreased of late years?

For example, 234 dental students were registered in 1895 as against 161 in 1902. Further, 4,901 practitioners' names were contained in the Dentists' Register for 1895, as against 4,641 in 1902. Comparing the Dentists' with the Medical Register for the above-mentioned years, it will be found that the number of practitioners on the Medical Register has increased, from 33,601 in 1895, to 36,788 in 1902.

This great disproportion in the number of men practising these two branches of surgery should not in my opinion exist, seeing the rapidly increasing population of this country, and the greater prevalence of dental disease.

It is evident from the figures given that the dental profession is not overcrowded, and the question arises as to why young men do not enter our dental schools.

The increased severity of the preliminary and professional examinations, of which I shall speak later, may deter some eligible men from joining our ranks, but it is far more probable that a much larger number keep aloof on account of the lowering influence upon the profession produced by the enormous number of advertising dental companies. These institutions, consisting mainly of unqualified men, degrade our speciality, but as the profession is recruited by qualified dental surgeons, so will the unregistered practitioners disappear.

Let me assure you that the examinations themselves are no hindrance, for any man possessed of average ability, education, and diligence, can become possessed of a diploma.

It may be thought that worldly success is assured for all of you, seeing the number of our profession is comparatively small, but success in life is relative, and Guy's men are expected to be ambitious, and to strive to attain the highest ideals of life and practice. In order to be above the level of the ordinary man, it goes without saying that you must excel in your work, but you must possess another qualification equally necessary, and that is a real sympathy with the suffering of others. Call this quality by any name you choose—tact, knowledge of mankind, the personal element or kindness—but remember it is an essential and important factor for consideration. Indeed, I maintain that no man has failed in any sphere in life without having lacked one of these qualities, or given way to vice.

Aim at the highest standard of work, inculcate habits of industry at an early age—we are all the creatures of habit—strive to do everything in the best possible manner, and never be slip-shod in your methods.

"Be not like dumb driven cattle;
Be a hero in the strife."

Cultivate a living sympathy with the feelings of your patients, put yourselves in their position, and let the "chair-side manner" on all occasions, whether in hospital or private practice, be as considerate and kind as possible.

Sir Joshua Reynolds declared that "those who are determined to excel must go to their work whether willing or unwilling, morning, noon, and night, and they will find it to be no play, but, on the contrary, very hard labour."

Again, concentrate for the time being all your study and attention upon the subjects of the curriculum—not omitting relaxation in the way of light reading, and open-air exercise for health's sake. The necessity of concentration of mind was early impressed upon me on account of the following disappointment in life. A fellow medical student, whom I had known as a schoolfellow of considerable ability, failed utterly at the hospital, simply because he digressed too much in his studies. He worked at abstruse subjects, but never knew his own particular ones sufficiently well for examination purposes, and being referred to his studies on many occasions he became disheartened, gave up all hope of obtaining a medical qualification, and eventually accepted the position of hospital dispenser.

In referring to the professional examinations a noticeable change of late years is the separation of the general from the dental part of the final examination for the L.D.S. Eng. The effect of this separation has been to compel students to obtain a high standard in each section, which is more difficult to accomplish than when the general and dental sections were combined. It is to be regretted that the altered conditions of the final examination have led students to devote more time to the study of anatomy at the expense of practical dentistry. No greater mistake can in my opinion be made than for practical work to be neglected, and the best way to overcome the difficulty is for the student to read at night, devoting as much of the day as possible to work in the conservation room. He must of necessity spend some part of the day at lectures and dissections, but his reading should mainly be done of an evening and little or none during the day.

It may possibly be that the student of the future will be unable to obtain the L.D.S. Eng. diploma within the minimum period of two years' hospital practice, and

that being so the extension of his hospital studies to two and a half years should benefit him in every way, although his parents, for financial and other reasons may hold a contrary opinion. My advice is, make yourselves thoroughly efficient operators at any cost, as the public will estimate you according to the standard of your practical ability.

The curriculum has been extended lately by compulsory attendances upon lectures on bacteriology and dental materia medica, and it is reasonable to suppose that the range of subjects may even be increased. Whilst speaking of the broader education now required for the license in dental surgery, I cannot help expressing a hope that the increased knowledge of chemistry, anatomy, physiology and surgery possessed by the present day dental student will induce him to seek a medical qualification. I know I am touching upon debatable ground, the opinions of experienced teachers differing widely as to the lines of advance for the wider education of the dentist, but personally I feel that the application of one's knowledge of anatomy, surgery, and pathology, is so useful, interesting, and fascinating, that it is undesirable for the student to forego the opportunity of taking the conjoint diploma if at all possible. It is considered by some experts that a degree in science is preferable for the dentist, but I maintain that the line of advance should be in the direction of a surgical qualification, dental surgery being a branch of the healing art; at the same time I do not for one moment belittle a degree in science or arts, or a higher knowledge or a greater proficiency in any branch of dentistry.

It is to be hoped that you will live to see the day when the resident British dentist will be found in every small town and village, in keeping with the local clergyman, doctor, and solicitor. This rural practitioner can be pictured as a modest man, of the social position of the apothecary of former days, content to earn a moderate income, satisfied by honourable devotion to his profession, and benefiting by the advantages and pleasures of a country life. If efficient dental treatment could be thus universally carried out, not only would much pain and disease be prevented, but the death rate of the country would be diminished, and the average duration of life prolonged.

In conclusion, let me say I have merely referred to some of the recent developments in our speciality to indicate that dentistry, like medical and surgical science, has made progress upon conservative lines. The sole object of this short address has been to endeavour to inspire you with lofty aims and a true professional spirit, and it is my sincere desire that each one of you may become a more capable man than he who now addresses you, and may you benefit to the full by the education received at Guy's, and in later life reflect lustre upon your school.

Finally, I wish you success and happiness, and I thank you for your patient attention to my remarks, which I trust have not wearied you.

After the introductory address a most interesting paper was read by Mr. A. E. D. Prideaux, on "Mastication," and with a somewhat short discussion on the same, owing to the lateness of the hour, a most successful meeting was brought to a close.

Sport.

Rugby Football.

GUY'S v. CATFORD BRIDGE.

This match was played at Berlin Road, Oct. 17th, 1903. We won the toss and Catford kicked off. After a few minutes it became evident that they were much stronger forward, and play soon settled in our territory. Their backs, no doubt acting under orders, helped their forwards by judicious line kicking, and the ball was worked down to within ten yards of our line. Then the Catford forwards heeled out promptly, and their half-back making use of the blind side, put his partner over our line wide out. The goal kick failed. From this to the end of the first half the Catford forwards controlled the scrums, but they lacked scoring power, and vigorous tackling and occasional good dribbling by our forwards (Saunders being especially conspicuous), kept the game going up and down the field. Harrison, when he got a chance, put in a long kick. At half-time Catford led by a try.

In the second half our backs were rearranged, O'Brien and Jones changing places. Our forwards seemed to be lasting better, and we got the ball now and then in the scrums. We now brought some passing off. On one occasion, after all the backs had handled, Morgan had only their back to beat when he unfortunately slipped. On another occasion Morgan had a drop at goal and missed it by inches only. O'Brien's line kicking was a feature of the half. It was some time before we scored, McEvedy getting over after a fine run by Morgan. O'Brien's shot at converting failed. Shortly after this McEvedy with a great rush, burst through and got over, only to lose the ball. Willan also scrambled over their line, but the referee ordered a 5 yard scrum. In the last three minutes our backs were passing when McEvedy was tackled with the ball and threw it forward. The Catford left wing three-quarter making use of an opportunity, picked up the ball, ran to Harrison and then passed to his centre, who scored. The goal kick failed. No side followed, a minute later we were beaten by two tries to one.

Remarks.—All the backs played well. The forwards have not got together yet, and should spread out when chasing an opposing back. They are far too gentle. If a man *will* not play the ball when fairly tackled, the game is to make him play it. Remember that the average referee will not help you, and the remedy lies in your own hands.

GUY'S v. CAMBRIDGE UNIVERSITY.

This match was played at Cambridge, as usual, on October 21st. The ground was wet and muddy, rain having fallen up to the time the match started. Cambridge kicked off, and found touch near the Guy's line, Horsley kicked over the line, and Harrison touched down. After the kick-out Cambridge still attacked, but a free-kick to the Hospital for "foot-up" relieved the pressure. Cambridge forwards were getting the ball in the scrum nearly every time, and their backs were only prevented from scoring by keen tackling. Mainprice marked and Sivright took the kick, but failed to land a goal. A scrum was formed near the Guy's line, and from this the ball went out to McNeil, who scored. A good goal resulted. Guy's were defending when half-time was called. Cambridge 1 goal, Guy's nil.

Saunders kicked-off, and for a short time Guy's attacked, Morgan and McEvedy making good runs. After this the hospital went to pieces, and tries were scored in quick succession by Evans, Ritchie, and a forward. McLeod converted one try. Towards the end the Hospital team tried hard to score, and after a good forward dribble the ball was taken down to the Cambridge line, where Archer scored a try. Morgan kicked an excellent goal. Time was then called, Cambridge 2 goals, 2 tries (16 points), Guy's 1 goal (5 points).

REMARKS.—Our team did not play at all well, both backs and forwards being at fault. The forwards seldom obtained possession of the ball, and the backs when they did have a chance, ran across the field and found the ball too greasy to hold.

Reviews.

The price of books submitted for review should in every case be stated.

Report of the Commissioner of Public Health for Queensland. We have been favoured with the report of the Commissioner of Public Health for Queensland, which is full of interest, and contains more matter than can fully be discussed in our columns.

Turning first to the drainage and sanitary arrangements, there appears to be much need for the improvements which endeavours are being made to carry out. In Brisbane, the capital, the conservancy system is still in force, with all the obvious disadvantages of such a system, in a large town; and evidence from other places, seems to point to the fact, than in the absence of the water-carriage system, there is real danger of typhoid fever being spread by means of flies. The pollution of natural water supplies is reported from several sources, as also in other towns the success which has attended the efforts of the Medical Officer of Health to prevent such dangers.

In dealing with food there have been several innovations with the year 1903; whereas formerly, compounds of copper alone were prohibited as ingredients of food, there have been added this year to the prohibited list, compounds of tin, lead, zinc, arsenic and antimony. As a further protection to the public strict regulations have also been introduced by which it is enforced that where any preservative is mixed with an eatable the nature and amount of such preservative shall be clearly printed on the label.

All preservatives in milk are declared injurious, but there is much to be desired apparently in the supervision of the cleansing, drainage and water supply of the dairies. There is, however, abundant evidence in the report of the thorough way in which the supervision and examination of foodstuffs is carried out.

In the part devoted to infectious diseases there are no points for very special comment; enteric fever is by far the most prevalent disease, its spread is attributed to various causes—contaminated water, insects, infected dust washed into water tanks, etc. The disease has been prevalent this year, the rate of incidence was 2·7 per 1000 of the estimated mean population, during the first six months of the year. The absence of efficient drainage systems, and the prevalence of typhoid fever, make the most prominent features of the report; it would not be very rash to conclude that they stand in the relation of cause and effect.

In conclusion, we must congratulate the Medical Officers for the many improvements set on foot, and end by thanking the Commissioner for his interesting report.

Comparative Odontology. A. S. Underwood. Pages 152, illustrations 77. Crown 8vo. Baillière, Tindall & Cox. 5s. net.

It is with great pleasure that we welcome this new publication of Mr. A. S. Underwood. To those about to begin the study of odontology it will, we feel sure, prove to be one of extreme utility. And not only to beginners will the book show its usefulness, but it will also interest in no small degree those who already have some knowledge of the subject, for although there appears to be nothing actually new or original in the subject as regards theories, all the matter is put before the reader in such a manner that his interest is at once likely to be awakened at many points which may have been lightly passed over before.

Mr. Underwood opens his preface by hoping that the book may render the study more attractive to the student, and this hope will certainly be realised; for everything is explained in such an attractive manner that one's interest does not flag at any point.

As a book for students, it is not intended that it should be read alone, but used in conjunction with one of the ordinary text-books it will prove invaluable. Most of the diagrams, too, are excellent. "Evolution" is Mr. Underwood's strong point, and he lays stress upon it on every possible occasion, and rightly so; for until its importance in connection with the subject is thoroughly appreciated and understood—and this is where students often fail—Comparative Odontology can never become an attractive study.

Specialities.

JEYES' MEDICAL FLUID AND JEYES' FLUID.

Jeyes' Medical Fluid and Jeyes' Fluid are both improvements on the once popular creolin, and each possesses more advantages than the latter. As an antiseptic and deodorant the fluid is excellent, and Dr. Klein's testimony coincides with our own experience. The internal use of Jeyes' Fluid we are not acquainted with, and in the absence of some skilled and steady investigation we cannot at present recommend it.

Change of Address.

Dr. J. M. Brydone has removed from Bright ward to 42, Welbeck Street, W.

Dr. Brooke Churchill, from Victoria Road, Sutton, to the Cancer Hospital (Free), Fulham Road, S.W.

Dr. Reginald C. Mullins, from Johannesburg, Transvaal, to West Hill, Grahamstown, Cape Colony.

Mr. A. W. Walker, L.D.S. Eng., from Odos Solonos, to Rue Lycabete, 14, Athens.

The Editor will be very glad to receive a postcard with notes of any change of address.)

Appointments.

CIVIL.

BYFORD, W. F., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer to H. M. Prison at Ruthin.

MORGAN, D. L., M.B. Lond., L.R.C.P. Lond, M.R.C.S., has been appointed Resident Surgeon to the Royal Sea Bathing Hospital, Margate.

NAVAL.

Staff-Surgeon WILLIAM BETT, R.N., has been appointed to the *Bedford*, and Surgeon STANLEY S. H. SHANNON, R.N., to the *Centurion*.

From the Gazette's Special Pathologist.

NOTICES.

J. W. S., BROAD CYLST.—Reaction acid, sp. gr. 1021, albumen absent, blood absent, sugar absent. Microscopical examination of the centrifugalised deposit: The deposit contains a normal quantity of squamous cells and leucocytes, and certain extraneous matter, and nothing of pathological significance is found.

PATHOLOGIST.

Pass List.

University of Cambridge, October, 1903.

DEGREE OF BACHELOR OF MEDICINE AND BACHELOR OF SURGERY.

W. F. L. Day.

DIPLOMA IN PUBLIC HEALTH.

G. Warwick Smith.

Final Conjoint Examination, October, 1903.

MEDICINE.—J. E. L. Bates, H. O. M. Beadnell, J. E. Collins, J. B. Copland, *W. Johnson, *H. S. Jones, E. N. Jupp, B. W. Lacey, *T. C. Lucas, E. L. Ward, *A. M. Webber, *R. Willan.

SURGERY.—*R. G. Anderson, *P. C. V. Bent, H. W. Bethell, *S. C. Bowle, R. E. Brayne, J. Bromley, C. M. L. Cowper, *W. Collins Lewis, M. G. Louisson, G. Nunn, J. F. Rey, G. A. Ticehurst, *F. H. Wallace, H. M. M. Woodward.

MIDWIFERY.—G. Carlisle, P. P. Cole, H. B. German, R. A. Greeves, H. H. Jenkins, B. Moiser, M. J. Mottram, F. Rogerson.

*Denotes completion of examination.

Second Conjoint Examination, October, 1903.

S. W. Daw, P. D. F. Magowan, I. Valerio, E. Wragg.

First Conjoint Examination, October, 1903.

CHEMISTRY.—D. W. Jones, W. J. C. Timberlake.

PRACTICAL PHARMACY.—H. G. Gibson, O. C. H. L. Moll, G. Nunn, C. M. Ockwell, J. E. Prentis, G. Wacher

Birth.

BYFORD.—On October 17th, at Pyrocanth House, Ruthin, the wife of W. F. Byford, M.R.C.S. Eng., L.R.C.P. Lond., of a daughter.

Marriage.

STEELE-PERKINS—HARRILD.—On October 27th, at Holy Trinity Church, Sunnindale, by the Rev. G. F. Watson, M.A., vicar of St. John's, Woolwich, cousin of the bride, assisted by the Rev. R. W. Ackworth, M.A., John Shirley Steele-Perkins, B.A., M.B., B.C. Cantab., M.R.C.S. Eng., L.R.C.P. Lond., eldest son of Alfred Roberts Steele-Perkins, J.P., Surgeon, of Exeter, to Elsie Charlotte Ann, younger daughter of Horton Harrild, Shrubs Hill Place, Sunnindale, and formerly of Westwood, Sydenham.

ED.—R. E.

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Calendar of Coming Events.

November, 1903.

Sat. 21.—Mr. Golding-Bird's take-in; Drs., R. Edridge and W. Reeve; Cl., W. F. Box.
1 p.m., Clinical lecture by Dr. Taylor.
G.H.R.F.C., I., v. Old Merchant Taylors, away.
II., v. Rosslyn Park II., home.
III., v. Ealing "A," away.
G.H.A.F.C., I., v. Beckenham, away.
II., v. Beckenham II., home.
G.H.P.P.S., Pathological Evening.

Mon. 23.—1.15 p.m., Clinical lecture by Mr. Bellingham Smith.

Wed. 25.—G.H.R.F.C., III., v. Royal School of Mines, away.
G.H.A.F.C., I., v. Leavesden Asylum, away.

Thur. 26.—Messrs. Jacobson and Sir Alfred Fripp's take-in; Drs., H. V. Mitchell and C. M. Wenyon; Cl., E. G. Goldie.

Fri. 27.—January Dental Appointment List opened.

Sat. 28.—1 p.m., Clinical lecture by Dr. Taylor.
G.H.R.F.C., I., v. London Irish, away.
II., v. Civil Service II., away.
III., v. Wasps III., away.
G.H.A.F.C., I., v. Old Cranleighans, home.

Mon. 30.—1.15 p.m., Clinical lecture by Mr. Higgens.

December.

Tues. 1.—January Appointment List opened.
12 noon, Mr. Rowell's Demonstration on Anæsthetics.

Wed. 2.—1.30 p.m., Clinical lecture by Mr. Golding-Bird.
G.H.R.F.C., III., v. Tonbridge School II., away.
G.H.A.F.C., I., v. Old Carthusians, home.
II., v. Sevenoaks School, away.

Thur. 3.—G.H.C.U., Members' Meeting.

Fri. 4.—January Dental Appointment List closed.

Sat. 5.—1 p.m., Clinical lecture by Dr. Taylor.
G.H.R.F.C., I., v. Northampton, away.
II., v. Old Millhillians, home.
III., v. Old Blackheathens, away.
G.H.A.F.C., I., v. Tunbridge Wells, away.
II., v. Alleyn 2nd XI., home.
G.H.P.P.S., Paper by Mr. K. Black on "The Relation of Dental Caries to Disease."

Guy's Hospital Gazette,

NOVEMBER 21, 1903.

Some Practical Points in the Pathology and Treatment of Tuberculosis of the Testicle.

CLINICAL LECTURE BY MR. W. H. A. JACOBSON.

(Continued from October 10th.)

I pass on to *other causative factors* in this most important disease, and I take (1) *Gonorrhœa.* You know that, sometimes, gonorrhœa having reached the deeper urethra travels along one ejaculatory duct, extends along the vas deferens, and so reaches the globus minor. Here the gonococci are delayed, as is the seminal secretion travelling in the opposite direction. Note the effects of the gonococci at this spot. They are, erosion of the delicate mucous membrane—at this spot the columnar ciliated epithelium of the epididymis merges into the columnar of the vas deferens, and you will remember the predilection that the gonococci have for this variety of cell—next, the delicate connective tissue is infiltrated, and the narrow lumen still further narrowed, leading to further delay of the contents, catarrh and, readily, a pyo-catarrh, for the gonococci are pyogenic and can bring about suppuration as well as the special disease of which they are the cause. The above damage once done, it is easy to see how readily, if the tubercle bacilli come along this way, that tuberculosis may follow. As to the frequency of tuberculosis after a gonorrhœa, Zeiss puts gonorrhœa first of all predisposing causes. Kocher satisfied himself that gonorrhœa had predisposed to tuberculosis in fourteen out of fifty-two cases of tubercular epididymitis. There are certainly

two dates for us to bear in mind at which the one disease follows the other: (*a*) Where the tuberculosis follows rapidly on the gonorrhœa. Here there has probably been some pre-existing quiet tubercular focus which has been quickly lit up into activity by the gonococci; (*b*) Where an interval, and it may be a considerable one, elapses between the gonorrhœa and the tuberculosis. Here the gonococci have prepared the soil for the tubercle bacilli in the way I have described above. You will not fail to note the above two ways in which the two diseases follow each other. And there are two more points bearing on this sequence to which I would draw your attention. I have spoken of tuberculosis of the epididymis being, in the large majority of cases, slow and insidious in its commencement, and thus limited to the epididymis for some time. But if a patient with slight dulness at one apex, slightly prolonged expiration and some crackling on inspiration, becomes the subject of gonorrhœa, and then of tuberculosis of the epididymis, the interval will be a short one, three, four, six weeks. But more, the progress of the tuberculosis will be a more acute one with pain, inflammation, and rapid destruction of the epididymis, and formation of fistula and quick extension to the testicle. One more point with reference to tubercular epididymitis following on gonorrhœa deserves attention, and that is the occasional occurrence of a tuberculosis which is not local but general and miliary. Such cases are fortunately rare for they are of the gravest significance, especially in private practice. Teirlink and Birch-Hirschfield mentioned such cases occurring in German and French conscripts, but the most instructive one of all is given by Bardenheuer. The patient was a surgical colleague of his, and the clinical history and the results of the necropsy are given with minute and most instructive detail. The patient, æt. 36, described as being of unusually fine physique and stature, and without the least phthisical taint, contracted a gonorrhœa at 25; three years later a tender swelling appeared on the right side of the scrotum, and a few years later, one on the left side also. These never disappeared. The patient believing them to be gonorrhœal epididymites employed massage to restore the lumina of the ducts, and by this step I imagine that he very probably aided the dissemination of the tubercle bacilli. Two years before his death, a fistula formed in the right scrotum. One and a half years before his death he married.

On the 1st December, 1885, both epididymes and the lower part of the vasa deferentia were removed by Professor Bardenheuer, and shewed characteristic tubercular changes. In January, 1886, the patient was troubled with much cough, with ropy, bloody mucus, and extensive moist rhonchi on both sides. He died with increasing dyspnœa January 23rd, 1886. The necropsy gave abundant evidence of miliary tuberculosis of lungs, liver, spleen, etc.

(2) As another very possible causative factor you will, when in practice, have to remember *Sexual Excesses*. Some of us discussed this question in the case of the patient sent to me by a practitioner in the East End, last Wednesday week. Such cases are usually aged about 25, they have, perhaps, been married a few months, they are of feeble physique and poor vitality, and their surroundings are unhealthy, all conditions bringing about poor power of resistance to the entrance and adhesion of bacilli, and also likely to prevent the formation of any preventive reaction, which might produce an inflammatory tissue wall to encapsule the bacilli and give the organism, if better surroundings can be given, a chance of destroying them. In such cases the tubercular epididymitis is likely to be quickly bilateral and to run a rapid course. (3.) *Injury*. Bardenheuer's experience leads him to put this first. As in the other organs, viz., bones and joints, the injury is a slight one and often repeated. In my experience injury has been scarcely ever mentioned or allowed by patients, who, though often much too careless as to the cause and history of their trouble, would be certain to remember any injury to so sensitive a part. Moreover, injury when it falls on this region—and I need not remind you how well the testes are protected anatomically—usually affects the testes and not the epididymis. Primary tubercular orchitis, not epididymitis is very rare. The three cases I have seen have been in children, and in two there was a distinct history of an

injury. I shall mention one case in which a bilateral tubercular epididymitis was distinctly set up by injury, when I speak of treatment.

I will now ask your attention to the third heading of my abstract, *i.e.*, Different modes of infection of epididymis.

i. By the blood-stream. I believe this to be by far the most frequent mode of infection, the bacilli gaining access to the blood-vessels by inhalation, food, etc., or from some primary tubercular focus. (*a*) Tuberculosis of the epididymis is from my experience much more frequently primary. In other words, in the majority of cases there is no evidence of any other tubercular focus already present. Having gained access to the blood stream, the bacilli tend to lodge and to adhere to the vessels in the epididymis, partly owing to the functional activity of the organ, its vascularity, and perhaps, as stated by Jani, the thinness of its vessels. However this last point may be, we see in the vascularity the same predisposition as you are familiar with in tuberculosis of vascular parts, such as the epiphysial lines in the long bones and the vertebræ, and in the pia mater. Access once gained to the vessels of the epididymis, adhesions and further invasion is promoted, especially if the individual's personal vitality and surroundings are favourable to the progress of tuberculosis, by the anatomical and pathological points with which I have fully dealt, and which tend to bring about catarrh, pyocatarrh, and the disease gaining a firm hold. (*b*) In other cases the bacilli again reach the epididymis by the blood-vessels, but here from some pre-existing primary focus, *e.g.*, old vertebral or joint disease, or phthisis. These cases are rare, in the great majority tuberculosis of the epididymis is, I repeat, primary and, at first, the sole lesion. Those of you who have had frequent opportunities of seeing necropsies in phthisical patients, will remember that the invasion of the genital system is by no means a frequent occurrence. The fact that tuberculosis of the epididymis is usually primary should make its surgical treatment far more successful than in other tubercular lesions, were it not for the peculiar value of the organ at the time at which it is usually attacked, and the natural unwillingness of patients to submit to the same radical treatment that we know perfectly well is the only one that promises success in the earliest stages. And the same fact should make us eager to test in every way the value of epididymectomy, which we shall see ought to have the great advantage of bringing patients earlier to us for operation, however doubtful its other claims may be.

iv. Treatment.—Here we must consider non-operative and operative steps.

A. Non-operative. This as a rule should be only exceptional and not the treatment of choice. But it is one thing to say so, and quite a different one to carry it out, however strongly one is convinced of its truth. It is here that one of the most serious dilemmas will meet you in after days, when by yourselves in private practice. On the one hand—we will take the usual clinical course which these cases offer to us—a patient entering on the prime of life in full sexual vigour, comes complaining of a little discomfort and weight in one testicle. On examination you find a small hard nodule the size of a pea or a small nut in one epididymis. There is no tenderness or pain, the rest of the epididymis and testicle appear healthy. You examine the rest of the body, not forgetting the prostate and vesical ends of the vas deferentia: all appears sound. You advise a suspender and perhaps a little belladonna ointment. In a fortnight there appears to be no change for better or worse, the process is evidently a slow one. There seems to be nothing pressing. The patient's surroundings are at the present time healthy. Perhaps you now gather that he is engaged to be married. Let us now consider the other side of the question. You know that sooner or later the disease is certain to spread. It is as absolutely certain that here as in the cancellous tissue of bone, in a gland, along a synovial membrane, infective granulation tissue will form and reach other parts. You naturally shrink from mentioning the word castration, and yet your experience, pathological and clinical alike, render you certain that early thorough removal is the only treatment which will be successful with any accessible tubercular forms. The patient is perhaps sensible, and having heard the nature of his complaint

asks you about waiting. Will the deposit go? What will happen if he waits and has nothing done? You know the answers to these questions. If the man's surroundings are good, if his vitality is active, the deposit will, to a certain extent become encapsuled, and the process for a time remain inactive. But you know that this barrier may at any time break down, and that sooner or later it is certain to do so from some slight injury, or that impairment of vitality, which is sure to follow some time or other. In other words, the deposit will only, at the best, remain in a state of an armed truce, menacing other parts with infection. What are these parts? As they include from the intimate connection between the two the deeper parts of the genito-urinary tract, they are of the utmost importance. Let us consider them briefly seriatim.

i. Along the vas deferens. Bardenheuer considers this extension, save as far as the initial part of the vas is concerned, to be a late one, one which takes one, two or three years, and which always occurs subsequent to extension to the testicle and the opposite epididymis. His explanation of this late extension to the peripheral, deep seated, and from its association with the bladder, more important part of the vas, is as follows:—He believes that the bacilli are detained in their passage to the deeper parts of the vas by the tubercular deposits in the epididymis and proximal part of the vas, while deposits consequently block the lumen of the tube. I look on this explanation as incorrect and utterly unreliable, for these reasons. (1) A vas deferens leading from a tubercular epididymis may contain here and there along its course living spermatozoa. Thus it is a mistake to teach that a tubercular nodule in the epididymis always renders the testicle of that side functionless. Again, where spermatozoa can travel tubercle bacilli can do so also. It is absolutely certain that a vas deferens leading from a tubercular epididymis may contain tubercular bacilli, though to the naked eye it may appear absolutely healthy. Such a vas, when subjected to the microscope, will often show here and there throughout its whole extent, an affection of its mucous coat, varying from a simple catarrh with fatty degeneration and desquamation of its epithelium to the presence actually of minute miliary deposits. I do not, myself, look on this, which I know to be a fact, as a justification for removal of the whole vas in every case of castration or epididymectomy. Such a step adds greatly to the severity of the operation in patients who are not always by any means good subjects for operation, and I am convinced that if the chief and more advanced focus below in the epididymis or testis is removed, and the patient's vitality improved thereby and by other means, the organism will often be able to deal with the far smaller collections of bacilli in the deeper parts of the vas, as they have not yet gained much hold. But the above facts are a serious fallacy in Bardenheuer's view as to the extension along the vas deferens being always a late one. (2) We know that while the more superficial parts of the vas may be healthy, a rectal examination often shows some thickening and enlargement of the vesical end, often spoken of by text-books as involvement of the vesiculæ seminales. You know from your anatomy that at these ends the vasa become sacculated and their muscular walls much thinner, in these two respects being approximated to the structure of the vesiculæ seminales. These anatomical facts render the passage of any fluid along them slower, and thus favour the adhesion (a point on which I have laid much stress) of tubercle bacilli.

ii. To the rest of the genito-urinary tract. I believe this to be absolutely certain in the long run if the tubercular epididymis, or epididymis and testicle, be not removed. The order of invasion shows to my mind points where the anatomical conditions are favourable for the adhesion of the bacilli. (1) Vesical end of vas deferens. I have mentioned two points which concerns every thoughtful surgeon here. (2 & 3) To vesiculæ seminales and prostate. Here also in the sacculation of the one and the long tubular branched ducts of the other, in the mucus present in both organs we find conditions favouring the adhesion of the bacilli. (4) Urethra. While the anterior part of the urethra is not, as a rule, affected owing to the way in which it is repeatedly flushed out, the prostatic portion is always liable to be affected in cases where

the tuberculosis is of any standing. Remember this as a fact. If you are obliged to pass a catheter in these patients you will not only have the peculiar sensitiveness of the prostatic urethra which is present during active sexual life, but you may also be dealing in the neighbourhood of the colliculus seminalis, where the ejaculatory ducts, coming from infected vasa deferentia and vesiculæ seminales, open, with one livid red from undue congestion and superficially eroded with tubercular ulceration. (5) Bladder. This is certainly a late invasion. This may be explained in part by the presence of a collection of fluid and its periodical expulsion being unfavourable to the adhesion of bacilli. But though a late one it does occur, especially, from my experience, in cases where both epididymes are affected after a short interval and where the vitality of the patient is poor. And if once tuberculosis of the bladder is established, we have one of the most distressing of all surgical cases to deal with. I refer to the gradual removal of the mucous membrane of the bladder as the tubercular deposits coalesce and break down, the gradual conversion of the bladder into a stiffened inelastic sac, and the consequent constant dribbling away of urine, and its results. (6) Ureters. This again is, as with the bladder, a late extension in this the ascending form of tuberculosis, perhaps from the same reason that the urine is constantly washing them out. But I would remind you that the obliquity and narrowing of the very lowest part of the ureter must somewhat delay the passage of urine here, as shown by the occasional formation of a calculus at this spot; this delay must favour the adhesion of bacilli. Certainly this part of the ureter is not infrequently affected, whether in ascending or descending tuberculosis.

iii. To the Testicle.—Bardenheuer is, I consider, unreliable in the emphasis he lays on their complication being usually a late one, taking, in his opinion, a year or more. His reasons are three. (*a*) Tuberculosis of the epididymis nearly always begins in the globus minor, and as you know this is only connected to the testis indirectly by connective tissue. (*b*) The corpus Highmorianum has, by means of its fibrous tissue, a protecting influence on the testicle. (*c*) In none of his cases of epididymectomy did relapse take place in the testicle. But on the other hand I must ask you to remember the following:—(*a*) Bardenheuer's work, most valueable as it is, is based upon twenty-two cases of epididymectomy and was published in 1886. As far as I can gather from German surgical literature and the German surgeons that I have met, he has not published any further and later results. (*b*) Bardenheuer understates the frequency with which tuberculosis of the epididymis attacks the globus major. Here, of course, the connection between epididymis and the testis is direct through the tubes which connect the two, and thus, the testicle is more easily invaded. (*c*) Tubercular deposits in the testicle are not easily identified, not even when the tunics are divided including the parietal vaginalis. (*d*) While, as far as I know, caseous deposits are not common in the corpus Highmorianum, another form which tuberculosis takes sometimes, that of fibrous granulation tissue, infective, though perhaps not highly so, is by no means uncommon in the corpus Highmorianum. The bacilli are not numerous in this fibrous tissue, but their vitality is persistent. At the French Surgical Congress of 1900, in which the subject of tuberculosis of the testes was fully discussed, an interesting instance of the above was mentioned. For thirty years a patient, refusing operation, carried about with him this tubercular infiltration of each corpus Highmorianum. At the end of this long period his fate found him at last, the mischief suddenly blazing up and proving rapidly fatal by extension to the urinary system.

iv. To opposite epididymis.—While I believe that Bardenheuer is incorrect in his statement that this sequel is invariable, a point to which I shall allude later, it is a very common one. Though it is obviously one of the greatest importance, it has not been sufficiently recognised in this country. The opposite epididymis may be attacked quickly, within four or six months, or at a much later date, two years or more having elapsed. Here of course a fresh infection is possible.

v. To scrotal skin, with the formation of fistula.—You are familiar with the process here,

the same as in the case of the cervical glands. In each case the fistula leads to mixed infection with the risk of increased activity of the tuberculosis, and of breaking down of any barrier which the tissues have raised up against the tubercle bacilli. In each case spontaneous healing may take place but is usually only temporary, imperfect, and one that exposes the patient to risks to which I have referred and shall do so again a little later.

vi. To the tunica vaginalis.—If this serous sac be opened in cases of tuberculosis of the epididymis and testis, it will be found to show very different conditions. The commonest, in my experience, are (1) either a moderate degree of hydrocele fluid which does not contain the bacilli, or (2) obliteration of the sac, more or less completely. (3) In some cases tubercular pus and caseous products may be present and this may be of much importance. If present in adults it is an indication for castration; when present in children it may, if the processus funiculo-vaginalis be open, lead to infection of the general peritoneal sac, just as, if the same process be not closed, a tubercular peritonitis may lead to tuberculosis of the testis and epididymis.

To return to the subject of treatment:—

A. Non-operative treatment. I have said that this should be quite exceptional. It may be the method of necessity, it should never be that of choice, owing to its slowness and uncertainty, nay, more, the risks inseparable from it. I consider the following to be the only indications:—(1) Cases, not common, where established phthisis co-exists with genital tuberculosis. (2) In advanced cases of genital tuberculosis with tubercular disease elsewhere than in the lungs, such as the bones, vertebræ, etc., which will not be benefited by any operation on the testis or epididymis. (3) Occasionally in bilateral disease where the patient is young and naturally shrinks from the bilateral castration, which I believe to be the wiser step. In such cases the rank of life and the resisting power of the patient will influence us in resorting to non-operative treatment only. I will mention a striking case. In March, 1896, or seven years ago, I saw a young manufacturer, æt. 34, from one of our Midland towns, with bilateral tuberculosis of the epididymis and a fistulous opening on the right side. In the September of 1895, both testes had been bruised by some one sitting down suddenly on his lap, and, as it unfortunately happened, on some keys in one of his trousers' pockets. The right epididymis soon enlarged, and after some weeks suppurated and discharged, with a fistula, leaving the whole epididymis enlarged. The sinus persisted and, five months later, the left epididymis became the seat of a hard swelling. On this side also the whole epididymis was affected, and showed all the features usually met with in tuberculosis; on each side the globus minor was more affected than the rest. The left vesicula seminalis was distinctly enlarged and hard. He was anxious to be married at the end of the year, or in about nine months' time. As a partner in a large manufacturing business he was well off and happily could be his own master. I sent him away to North Berwick for a month, where he played golf from 9.30 a.m. to 6.30 p.m., took strychnine in the form of Fellowe's Syrup of the hypophosphites, and drank the very best of the Australian wines. In June, 1896, the sinus on the right side had healed, but a minute one had appeared on the left side, caseation having evidently taken place here in the globus major. Both testes appeared to be natural. There was no pyrexia, and save for the state of the left vasa seminalis the mischief appeared to be quite local. The sinus on the left side soon healed, and when I saw him again towards the end of 1897 he had been married nearly a year. The sinus on the left side had re-opened and led down to a distinct nodule in the epididymis. I have not seen him again, but his medical man was good enough to send me a report of him a few weeks ago, January, 1903, or eight years after the beginning of the trouble. "(1) All is sound outwardly. (2) No evidence of frequent micturition or caseation to the bladder, etc. (3) Last time I mentioned the matter, he said coitus was practised once or twice weekly and was satisfactory. There are no children. (4) His general health is splendid and he has increased in weight, I should think two stone. (5) No sweats or other clinical signs." I must warn you, gentlemen, that the result in this case has

been absolutely exceptional, that the patient's surroundings and vitality were most favourable, and that he was able to place himself under the best circumstances for improving them in every way. Again, and this is the most important point, I do not look on this patient as cured. I consider that the epididymes still contain small deposits, perhaps cretaceous, but for all that infective. Had I time I could tell you of cases where such cases have proved fatal after long apparent innocuousness. For six years the sinuses remain sound, then a gonorrhœa is contracted, followed by opening afresh of the sinuses, tedious burrowing of pus in the perinæum, and enlargement of one vasa deferens. In another case a young medical man, under thirty, had similar bilateral tubercular epididymitis with sinuses. He went to one of the Colonies and lived there for eight years, when tubercular cystitis appeared, secondary to mischief in the vasa deferentia and prostate, and proved fatal. I could quote other cases in which a like fatal result has been brought about by tubercular caries of the vertebræ, a complication to the comparative frequency of which Sir W. Bennett has drawn attention, in another by tubercular meningitis. During the interval which has elapsed between the caseation and suppuration in the epididymes and the onset of the other complicating tubercular lesion, an interval often as long as five, six or eight years, the deposits in the epididymes have been quiescent, and, to the patient's mind, quite innocuous. I will conclude with one case given by Prof. Senn, in his Principles of Surgery, p. 541. The patient, aged 35, had been married ten years, but was childless. When 26 years, he had noticed small hard swellings in each epididymis. Seven years later, when he was 33, he had cystitis not relieved by treatment; when he was 35 the left knee-joint became swollen and painful. At this time his temperature was from 100° to 103°. Pyonephrosis with perinephritic suppuration followed, and was relieved by nephrectomy.

B. Operation.—I will only refer briefly to, (i.) The cautery, and (ii.) The curette. To the first, one much used in France, there are the strongest objections, with its tedious sloughs, and interminable suppuration and fistula. The curette is usually as inadequate as it is in the case of tuberculous glands. Only the soft breaking down material can be got away, the bacilli situate in the firmer tissues beyond escape. Perhaps the most noteworthy proof of the futility of these modes of treatment is the way in which the aspect of Continental surgeons, especially the French ones, has changed toward them. Up to very recently they have practised scarcely anything else; for the last two years they have very largely given them up for epididymectomy. It remains for me to discuss the operations of epididymectomy and castration; of the former some of you have seen two cases under my care in Naaman ward.

(iii.) Epididymectomy. Advantages claimed if early, even if bilateral. (*a*) Patients are likely to give their consent earlier and thus we shall avoid that pernicious habit of waiting and deferring active treatment until too often the disease has extended beyond our reach. (*b*) If performed early the operation preserves the testes of the patient. Thus these are said not to waste. This is certainly true of the first year. I have no experience beyond this time, having only lately performed the operation. Now if an organ does not waste, it must have a function. What is the function of a testis from which the epididymis has been removed? Now the patients are, according to Bardenheuer, potent, though of course they are sterile. What is the value of the testicle, and what is the fluid ejaculated and whence its source? The testis has an influence on the healthy structure and functions of the prostate, vesiculæ seminales, Cowper's glands which together form a fluid which increases the amount of that ejaculated in coitus. Time will not allow of my going into the matter at length, but I may point out that this influence of the testicle on the other organs is shown by the non-development of the prostate when the testicle is absent or removed in early life, and by the fact that some of the enlarged prostates of later life, especially when over vascularity takes a large share in that enlargement, diminish in size very markedly after castration. Thus, a testicle left after epididymectomy does not waste, because it has the function still of reacting on

and influencing the structure of the other glands mentioned above. Thus a certain fluid is still ejaculated and the patients are still potent though sterile. The fluid is small in amount but it appears from Bardenheuer's cases to be sufficient to allow of satisfactory coitus being practised once or twice a week. If this be correct, and if it be found for the patient's health, considering what we know of the pathology of tuberculosis, the advantage of epididymectomy over castration is, obviously, very great. But I will take this opportunity of drawing your attention to two points which Bardenheuer appears to have overlooked. One is the advisability of preserving the sexual function and power. We know as a fact that however successfully we have operated for tuberculosis, whether on a bone or joint, or when we are dealing with a healed vomica in the lung, that the structure and function of the part is weakened, that we may have left behind foci of disease, though exceedingly minute, and that the part in future should not be taxed in any way. Whether advising epididymectomy because it preserves the sexual power is in accordance with the above fact, as we know that the organ is left a damaged one, and that foci of disease may be present in the scar or in the testicle itself, appears to me to be extremely doubtful. However, here the decision must be left to the patient, after the doubts and risks have been explained to him. Time and a fuller experience of the results of epididymectomy long and carefully watched will alone clear up this point.

Another point which Bardenheuer seems to have left quite unconsidered, is the credibility of the patients in their statements to him as to the preservation of sexual power after bilateral epididymectomy. All I will say is that this organ is not one where we easily get complete or truthful statements as to its employment. I pass on to the indications for early epididymectomy. (*a*) The best cases are certainly those where only one or two nodules are present in the epididymis with little if any softening. In other words, cases in which there is little peri-epididymitis or matting of the epididymis to adjacent parts, and thus the line of position between the testis and epididymis along which we have to work is easily distinguishable. (*b*) Cases which are less favourable, but for which the operation is, according to Bardenheuer, not unsuitable, would be these where the whole epididymis is involved, suppurating and showing fistulæ, but where the testis itself is not involved. I have already spoken of the great difficulty of being sure as to the state of this organ when the deposits are small, deeply placed, or when the tuberculosis takes that fibrous form of infective tissue met with in the corpus Highmorianum to the importance of which I have already drawn your attention. A palpable deposit in the centre of the testis, or multiple deposits at some distance from the corpus Highmorianum, of course prohibit epididymectomy. I am of opinion that if justice is to be done to this operation, which is about to stand its trial in this country, it should be reserved for the first most suitable class of cases where the disease appears to be clearly limited to the epididymis itself, when there is no extension to the skin, and when the line of junction between testis and epididymis is to be distinguished. These conditions were present in a middle-aged German, one of whose testes had been removed elsewhere a year ago, and also was sent to me with tuberculosis of the other epididymis. Epididymectomy was easily performed. The wound quickly healed and the testis has remained sound. But I will say, at once, that of my few cases of epididymectomy none has been performed more than eleven months, and they will require careful watching before they are of any real value. In the second case in which some of you have seen epididymectomy performed recently in Naaman ward, the favorable conditions on which I have laid emphasis were not present, and the result was unsuccessful. The patient was a young man whose right testis had been removed for tuberculosis a year before at one of our seaside watering places. He was sent to me with tuberculosis of the left epididymis, mainly affecting the globus minor, the skin over this being involved by caseation. In addition he had evidence of tubercular cystitis. I was compelled to advise removal of the remaining testicle. The patient was however so depressed at the thought of this step that I decided to try and save the

testis by epididymectomy. On cutting through the junction between the globus minor and testis, a junction effected by connective tissue as you know, a caseating focus was entered. Curette, scissors, pure carbolic acid were employed. I did not cut through the tunica albuginæ as the necessary sutures to prevent a hernia testis would not have held. The wound healed, but in three weeks a swelling reappeared which was clearly a persistence of the old tubercular focus and increased steadily. Castration was performed, and before the patient left, his condition had greatly improved, and by the aid of injections of Lot. Hyd. Per. 1–5000 the interval between micturition had passed from half an hour to two hours. The outlook in this case is, however, very gloomy.

Now as to *the chief steps of epididymectomy and possible complications and troublesome sequelæ*. The parts being duly cleansed and the patient anæsthetised, the affected side of the scrotum is held so as to present the diseased epididymis to the operator. An incision is made near this sufficiently free to expose the lower part of the cord above and the testicle and epididymis below. The tunica vaginalis is freely opened and the junction of testicle and epididymis scrutinised. With blunt-pointed scissors the surgeon carefully snips along this junction, beginning at the lower end of the globus minor. As this and the body are freed the epididymis is dragged away from the testicle. The globus major is now reached, which is, of course, connected to the testicle by the vasa efferentia. Especial care must now be taken to avoid the spermatic vessels. These lie on their way to the testicle on the inner side of the epididymis. The lower part of the cord should now be separated into two bundles. The vas deferens, posterior spermatic veins and the branch of the spermatic artery to the epididymis are drawn to one side, and then the rest of the spermatic veins with the spermatic artery are defined and traced down to their point of entrance into the back of the testicle, and held aside in the opposite direction. The junction of testicle and globus major is also very carefully snipped through close to the latter. The epididymis is now free with the vas deferens and posterior spermatic veins. The incision should be next prolonged to the external abdominal ring and the vas deferens drawn down and inspected.

In the early cases for which alone epididymectomy is in my opinion suited, it will be needless to pursue the vas deferens higher, and on the advisability of this step I have already spoken. All bleeding points should be carefully secured owing to the risks of a hæmatoma and its infection in this region. Any weak point in, or actual damage to, the tunica albuginea, should be sutured with fine sterilized silk. As a rule, there is a good deal of oozing, and it is well to put in a drainage-tube for twenty-four or forty-eight hours. As the upper part of the wound will be the lowest part if the scrotum is kept well upon the pubes, as it should be during the after-treatment, the drainage-tube should emerge here. The scrotal incision is united carefully. I have not spoken of removal of affected scrotal skin, infection of the wound with tubercular pus, excision of foci in the testicle and subsequent suturing of the wound thus made, treatment of a tuberculous tunica vaginalis, partly because in early epididymectomy these should not have to be faced, and also because I have already occupied your attention too long with one and the same subject. I will bring these two clinical lectures to a close by pointing out *some possible sequelæ and complications of the operation of epididymectomy*. They are (1) difficulty in making out the boundary between the testicle and epididymis. (2) Injury to the spermatic vessels. That this is a real risk is shown that Bardenheuer himself had four cases amongst his earlier ones in which castration was required on this account. (3) Tubercular infection of the wound. (4) An enlarged tender testicle ; this, which may be only an orchitis from handling, will always arouse the suspicion of tubercle. (5) A tedious fistula. According to Bardenheuer this is a frequent sequelæ, taking six weeks to heal. (6) Subsequent hydrocele.

And now, gentlemen, I trust that I have said enough to convince you of the need of our making a trial of epididymectomy in suitable, that is early cases. The importance of the disease, the most unsatisfactory results of

palliative and waiting treatment, unwillingness to advise and to accept the only alternative, urge strongly that this trial should be made, while, the fact that this subject has been one of the chief matters for discussion at the French and German Surgical Congresses in 1900 and 1901, emphasises the call upon us to test carefully this operation, and to weigh justly and candidly its results as compared with those of castration. Had time allowed, I should have much liked to contrast early castration with early epididymectomy, the chief questions which arise, the indications, as I consider them, for castration in tuberculosis, and to put before you the results of these German surgeons, especially those of Bruns of Tubingen and Simon of Heidelberg, who, unlike Bardenheuer, are advocates of castration. These surgeons have followed up their cases, one 115 for 50 years, the other 107 cases for 27 years, and prove to us how favourable these results of castration are.

For myself, I am of opinion that sad as this mutilation is, it is the only treatment which is in accordance with all that we know of the Pathology of Tuberculosis. But I desire to keep an open mind with regard to the recent operation of epididymectomy, and as this step and the subject of tuberculosis of the testes are not treated with sufficient fulness by our surgical writers, I have brought it before you in these two clinical lectures. On the other hand, I know well that too much of the same subject is wearisome to you, who plead that you are to-day, as Prof. Billroth wrote, "über sättigt von vorlesungen," or surfeited with lectures. So we will change the subject and take next time, "Some Cases of Acute Osteo-periostitis."

Change of Address.

Frederick Curtis, F.R.C.S., L.R.C.P., has removed from 43, London Road to "Lyndens," Redhill, Surrey.

Dr. W. J. Lindsay, from 327, Wandsworth Road, S.W., to 15, College Road, Bromley, Kent.

N. F. Ticehurst, M.A., M.B., B.C., F.R.C.S., from Guy's to 35, Pevensey Road, St. Leonards-on-Sea.

The Editor will be very glad to receive a postcard with notes of any change of address.)

Ichabod.

Can I believe the rumour !
Alas ! The Dressers' Room !
The energy of Sister
Hath now pronounced its doom.

For with improvements modern
Guy's ever moves apace,
The Surgery needs extension,
Extension– that needs space.

So let us pass the doorway,
And take a last look round ;
View those worm-eaten tables,
Those *B.M.J.'s* unbound.

How oft upon yon divan,
I've tried to take mine ease,
Forgetting that it harbours
Innumerable ———

Here one from couch to fender
Would stretch his wearied feet,
If "Lambs" went by to chapel,
He'd choose the window seat.

The advent of a stretcher
Perhaps disturbs our talk,
"Is it a fractured femur?"
Ah, no, for it can walk.

The manners here were often
Emphatically free ;
I *have* heard language stronger,
Than second cups of tea !

I've watched the verdant ward clerk
Delight the cloth to lay,
And also wash the platters
If 'twere the Sabbath Day !

What luxuries we fed on,
Tinned whales, cheese, greengage jam !
Still lingers on my palate,
The taste of week old ham.

Our orgies, former dressers,
Winked at from photos blurred ;
They won't be so familiar,
To alien walls transferred.

Alas ! To Boro' matrons,
This favoured spot must yield,
To little kids with "scarlet"
"Been 'oppin, Sir, and peeled."

With pickaxe phagocytic,
The working man draws near !
But I must close the chapter,
And give this "copper" beer.

PULEX.

Passim.

In another month Christmas will be upon us with all its attendant customs, and already there is that stir in the various camps which has become perhaps too familiar to so many. The Guy's man who has yet to spend his first Christmas at the hospital is greatly to be envied, for certainly at no other time is the life up here so interesting and so varied. For once in the year the grimmer realities are in abeyance, and for a few days an indescribable holiday spirit pervades the place, from the triumphant entrance of the Nigger into "Eyes" up to the last encore in Astley Cooper.

It has been most wisely determined, by those upon whom the onus of preparation largely falls, to cut down the number of the actual concerts, and whereas for the last few years every surgical ward has had its concert, this year there will be one concert for every two intercommunicating wards. This arrangement, resulting as it must do, in a humorous but effective concentration of forces, will tend, not only to raise the standard of the concerts, but at the same time to lessen the labours of those immediately responsible.

On the medical side there is talk of omitting the customary monster concert in Out-Patients', and this proposal should meet with the approval of all lovers of humanity. Out-Patients' with its two partitions is not adapted for the purpose, however successful its concerts may have been in the past, and, taking into consideration the fact that patients like a simple sing-song in their own ward just as much, if not more, than an organised combined concert in Out-Patients, perhaps it is just as well that this custom also is likely to die a natural death.

We are reminded, by the advent of the workmen in the East Court of the Surgical Buildings, that the alterations which we sketched so glibly in our last issue are soon to be accomplished facts. Since the shelter is urgently needed, every effort is being made to expedite its erection, and it is confidently expected that the new year will see it completed. If the weather behaves as it has done now for some years, the Women's shelter will be ready against the arrival of the really cold weather. For the next few weeks it will be our painful pleasure to gaze once more on the handiwork of that ultimately-indispensable, but incidentally-diffident person, the British working-man. In another part of the surgical block this same gentleman is justifying his reputation as a humourist, for he first removed one piece of brick from the bottom of the colonnade steps which were looking perfect at last, so far as the lay eye could judge. Shortly after this he replaced the brick, but lest we should be exalted over-much, he has removed the railings from the stone slope of which we are all so proud. We are anxiously awaiting further developments.

Both Science and Philosophy teach us, that most unpleasant things and unpleasant people, in spite of all appearances to the contrary, nevertheless fulfil useful functions in the world. It is, however, exceedingly difficult to apply this wise generalisation to the case of the antivivisectionist, and there are many reasons for considering him as a being set apart for the same style of judgment that he so persistently metes out to others. There are a few amiable theorists of this persuasion to whom one can listen, not only with respect, but with a certain amount of sympathy, but, unfortunately, when these essay any public expression of their views, it is always with a contemptible accompaniment of misrepresentations and lies. Not only are well-known and highly-respected English physiologists being accused to-day of inhuman practices by these malicious neurotics, but we note that the members of the Vienna Medical Chamber, to whom is entrusted the professional supervision of the medical men in the Austrian capital, have recently resigned in a body owing to accusations of a similar nature having been brought against members of the profession. We are glad to see that the issue of the conflict in this country has resulted in a moral and material victory for the physiologist.

We take this opportunity of welcoming to Guy's, Mr. A. E. Boycott, the new Gordon

Lecturer. Mr. Boycott comes to this hospital with a brilliant reputation for his research work, and loaded with honours won both at Oxford University and St. Thomas's Hospital, at which latter place he has but lately held the appointment of House-Physician. One of his most recent researches was, in conjunction with Dr. J. S. Haldane, concerning "Ankylostomiasis in Cornwall," the results of which were published in the Journal of Hygiene, III., 1903. The new lecturer has always taken a special interest in pathology, and has paid particular attention to the study of this branch of medicine. Guy's is, therefore, most fortunate in securing so distinguished a scientist as Lecturer in Experimental Pathology, and all will look forward to the course with the greatest possible interest.

In the several examinations that have recently taken place, Guy's men have been laying about them most valiantly, with the result that our pass lists compare most excellently with those of other medical schools. In the Final London M.B., 12 out of 17 passed, 3 of these being in the First Class. In the Primary Fellowship results there is the most cause for rejoicing, for these are phenomenally good, 8 men out of 10 having succeeded in this most difficult examination, while in the examination for the L.D.S. 19 men out of 21 passed in the dental part, and 21 out of 32 in the general part.

It is but voicing the opinion of an increasing number of men, to say, that the wooden tablet recently placed by the authorities over the fireplace in the Smoking-room is not the best way of expressing gratitude to the various gentlemen named thereupon, who have so greatly benefited the Club in various ways. To begin with, the shape of the tablet itself is a model of Philistinism, suggesting as it does the decorations on the walls of an almshouse or a family vault, and that a space should have been left vacant beneath the list as it now stands, will be interpreted by the uncharitable in a most unfortunate way. Surely there are other means, more dignified and more artistic, of expressing the enduring thanks of the Students' Club to these generous donors. In all probability, those most responsible for this erection have not as yet seen it with their mortal eyes in all its meeting-house austerity; we wish that they would remember, if it should occur to them to inspect the same, that there are those less fortunately placed who have to live with it.

In Dr. Alan Reeve Manby, another Guy's man has been honoured with the dignity of a knighthood on the occasion of the King's birthday. Sir Alan Manby, who is a member of the Victorian Order, lives at East Rudham, in Norfolk, and is Surgeon Apothecary to the King's Household at Sandringham and to His Royal Highness the Prince of Wales. He accompanied the Prince and Princess of Wales on their colonial tour in 1900. He was a student at this hospital from 1866 to 1869, and at one time held the appointment of Obstetric Resident. All will congratulate this distinguished Guy's man on this additional honour that has been conferred upon him.

Last Sunday week, being the anniversary of the formation of the present Chapel Choir, was the occasion of an overflow muster of the several members of this enterprising body, so much so that the number of choir stalls was too few to hold the zealous choristers. This is an excellent sign of the times. It is to be hoped, however, that now the men have apparently taken up the choir work in real earnest, the nurses' attendance in the same will not begin to fall off, as it has showed signs of doing of late. The ideal state is a combined choir, and this it has been up to the present.

Arrangements are being made for a Smoking Concert to be held in the Dining Room at the College, the particulars of which will shortly be seen on the notice boards. These concerts have been particularly successful of late, and there is every reason for expecting that the forthcoming one will be no exception to the rule. There has been for some time no dearth of local talent of quite a high order, and the only difficulty is the discovering of new men

to fill the places of those who are leaving. If there exists in our midst some mute, inglorious Leno, let him not fear to disclose his presence from any motives of false modesty, for he will be received with open arms. The Guy's Smoker is like unto no other Smoker, in more ways than one, and we would not have any freshman miss the opportunity of being present at such representative gatherings as these festivals usually are. We hear, too, in connection with this particular concert, dark hints of "special wheezes" and of "absolutely new business"; these should, no doubt, be taken with a modicum of salt, but there is always the thrilling possibility that they may be true!

On Thursday evening, October 30th, the Hospital workmen presented Mr. Pelling with a handsome testimonial in the form of a writing desk, on the occasion of his retiring from his post of foreman of the Works Department, which he has filled so ably. To carry on the duties of overseer of the many pieces of work always on hand in connection with this heterogenous fabric, must be a task for a giant. Guy's is losing a valuable servant in Mr. Pelling, whose post will not be easy to fill. We wish him every success in his new work, and can assure him of the regret we feel at his leaving us.

The next meeting of the Physical Society takes place this evening in the Wills Library at 8 o'clock, and is to be in the nature of a Pathological evening. Mr. H. F. Bell Walker is to take the chair. In another column will be found an able answer to a former correspondent's strictures on this society, which probably expresses the bulk of official opinion on the subject.

The treatment of fractures and certain other conditions by Massage, has once again become established, and the Hospital authorities have expressed their willingness to assist students in learning the various methods employed in its practise. The Matron has promised also to provide teachers, if requested to do so. The number and variety of cases treated by massage warrants the assumption that surgical and medical ward-clerks will be better equipped if they know how the treatment, they see ordered, should be carried out, and also how to carry it out themselves when necessary. Those who desire to obtain a knowledge of this art should send in their names to Mr. A. W. Ormond, and should the number of names be sufficient, a class will be started almost immediately.

Correspondence.

To the Editor of Guy's Hospital Gazette.

The Physical Society.

Dear Sir,—Your correspondent, Mr. Collins Lewis, in the last issue of the Gazette, makes the somewhat sweeping assertion that the Physical Society is the least flourishing of all the societies connected with the hospital. Unfortunately I cannot aspire to so wide a knowledge, and so cannot question his statement, but comparisons are odious and it is only reasonable to gauge the success of the Physical Society this year, by comparison with past years. If Mr. Collins Lewis takes the trouble to do this, I think he will find that the Society is doing, as well as ever, its useful and unobtrusive work. The average attendance this year has been 25–30, so that even after subtracting the total number of officials, some 10–15 remain to be counted in some mysterous way "on the fingers of one hand"! I have only four fingers on each hand, and I never noticed that Mr. Collins Lewis had more.

He seems quite to misunderstand the aims of the Society, the prime object of which is, not to draw and entertain large audiences, but to give to students, not to well-known general practitioners, an opportunity of putting forward their views and testing their knowledge by debate and criticism.

He thinks that the subjects of papers are thoroughly thrashed out by lecturers and in the wards. Perhaps so, but it is one thing to hear experts expound—it is quite another to formulate and express one's own ideas.

He regrets that young practitioners go out into the world unsophisticated and ignorant of their duties, and he thinks that a single lecture, or at any rate a series of lectures (by some well-known G. P.) would remedy this defect. Let him consider what a short time the student has to lay the foundation of his science, and then I think he will agree that the Physical Society is right, that the teaching of the hospital in general is right, in encouraging the study of pathology and diagnosis, giving to treatment and, well, medical deportment, comparatively little attention.

As Mr. Collins Lewis very well knows, we have lectures enough, and to remove the only opportunity students

have of hearing their own voices in public and substituting more lectures would be a great mistake; for Mr. Collins Lewis' second-hand idea would preclude debate or criticism on the part of students, because they are necessarily ignorant of this difference between hospital and general practice.

And after all, What is this difference? Being only a student my opinion can be of little value on this point, but I am hoping to find the same diseases outside as inside the hospital, though possibly in different proportions. If this is a delusion, why a minimum five years apprenticeship?

In conclusion, I think it is a pity that your correspondent has chosen a time like the present for advising the numerous "officials." As the fixture card is arranged for the present session, his advice, like most gratuitous advice, comes too late to be of any value, and his remarks might injure the Society (the interests of which he has so much at heart) in the eyes of younger members who have not yet learnt to value the Saturday evening discussions.—I am, etc.,

H. F. BELL WALKER.

Society of Medical Phonographers.

Sir,—May we be permitted, as President and Officers of the Society of Medical Phonographers, to bring the continued existence of the society and its usefulness, under the notice of any practitioners or students of medicine who make use of shorthand. Of late, the society has not come much under the notice of the profession, but its work continues. Its organ, the *Phonographic Medical Record*, is published monthly, and affords the means of obtaining familiarity with medical shorthand, together with definite information on practical medical subjects. The society has also issued a series of small original works in lithographed shorthand with the same object, as well as an extensive vocabulary of convenient outlines and guides to the use of shorthand both by the student and the practitioner. It has also held periodical examinations for students, in order to encourage their acquisition and use of shorthand.

The invaluable aid which it can give in medical work, practical and theoretical, in case-taking and note-making, is realised by all who have used it, as it cannot be by others; and the importance of its acquisition before medical studies are commenced is so great, that the society has endeavoured by every means to encourage this. But many practitioners, who make constant use of shorthand, have acquired it long after being engaged in practice. To all, students and practitioners alike, the society is open, and its members ready to give all possible help to those who are endeavouring to obtain the assistance of this time-saving art. The subscription to the society is very small, amounting only to 5s. per year for students and 7s. 6d. for practitioners.

The hon. secretary, Dr. Fletcher Beach, will be glad to give any further information and to receive applications for membership.—Yours, etc.,

DAVID FERRIER, President.
E. B. GRAY, W. THOMSON, C.B. } Vice-Presidents.
W. R. GOWERS, G. SIMS WOODHEAD, } Members of Council.
NORMAN PORRITT, Treasurer.
FLETCHER BEACH, Secretary,
Winchester House,
Kingston Hill, Surrey.

November 13th, 1903.

Nursing News.

MATRON'S OFFICE.

On October 24th, Sister Lazarus (Miss Powlett) left the hospital on account of ill-health. Sister Rennie (Miss Field), who has been acting as Sister-in-charge of the Wardmaids, was appointed Sister of Lazarus ward, and Miss E. Harradine, who completed her three years' training in January, 1902, and has since been on the Private Nursing Staff, was appointed Sister-in-charge of the Wardmaids.

On October 5th, Nurse Ripley (head nurse in John ward) left the hospital, having completed her three years' training.

On October 8th, Nurse Wilkinson (head nurse in Addison) left the hospital to take up her duties on the Private Nursing Staff, and Probationer F. E. Campbell was appointed to succeed her as Head Nurse in Addison ward.

On October 30th, Nurse F. Sheldon (head nurse in Luke) was transferred to Queen ward.

Musical Notes.

At the annual general meeting of the Students' Choir last Thursday, it was decided to hold a choir supper, the *approximate* date of which is December 18th. The idea is well supported by certain high authorities. Although this innovation does not necessarily create a precedent, it may act as a stimulant to intending members. An impromptu concert will be held after the supper.

It is to be deplored that the 5 o'clock rehearsals of the Glee Club are not better attended, as much is detracted from the usefulness and enjoyment of the combined rehearsals in this way. The separate practice is a necessary stage in the process of perfection required for the concert, and combined rehearsals cannot be held more frequently until this defect is remedied. The date of the concert is fixed for Tuesday, December 15th.

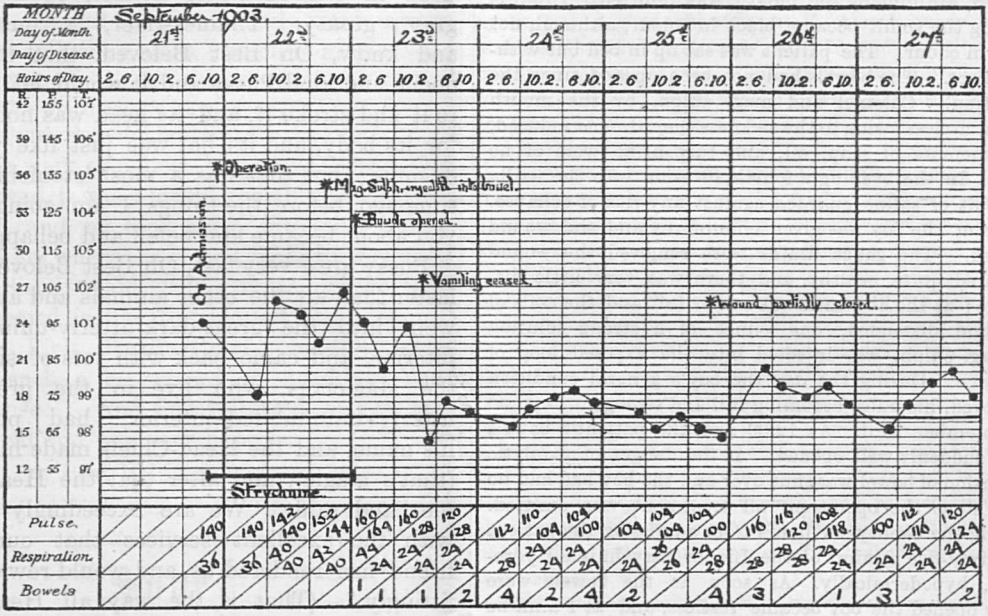
A Case of Acute General Suppurative Peritonitis.

Henry B., aged 9 years, was admitted into Clinical under the care of Dr. Beddard (the patient was towards the end of his illness under the care of Dr. Hale White) for abdominal pain and sickness. The boy's family and previous histories were unimportant; he was not subject to constipation and never had attacks of abdominal pain. The present illness commenced on the evening of September 19th—that is forty-eight hours before admission—with acute abdominal pain, situated in the right iliac region; later the same night he vomited several times; his bowels had been opened three times that day. On September 20th the pain was much less, and during the day he vomited three times, each time after taking fluid; the vomit was yellow in colour; he went to the closet twice, and believes he passed a small motion on each occasion, but is not positive of this. On September 21st the boy was much about the same, having vomited each time after taking barley-water; his bowels were not opened, and towards evening the abdominal pain became worse and generalised. He was brought up to the hospital and admitted.

Condition on admission.—September 21st, 9·30 p.m. Temperature, 101° F. Pulse, 140, regular, small and of low tension. Respirations, 36. The patient is a rather thin, weakly-looking boy, small for his age. He lies on his back in bed with his knees drawn up; his eyes are bright and slightly sunken, the skin hot and dry; he does not appear to be suffering very much abdominal pain; his mind is clear and he talks quite rationally. He complains of thirst, and his tongue is dry and coated with a brown fur. The abdomen is not distended, there is no movement on respiration, and the abdominal wall is tender, slightly œdematous, and rigid equally all over; liver dulness is normal, no tumour can be felt, and no peristalsis heard with the stethoscope; nothing abnormal detected by rectal examination. Other systems normal.

Progress and treatment.—On admission liquor strychninæ hydrochlor. 3 minims subcutaneously was given. A large soap and water enema administered was returned without result. Mr. Lane was called in and he decided to operate. The operation which commenced at 10.30 p.m. lasted half an hour from start to finish. A.C.E was administered, and the usual appendectomy incision, of about eight inches in length, was made. The tissues of the abdominal wall were slightly inflamed and œdematous. The peritoneal cavity was opened and some rather thin, turbid, *non-smelling* fluid escaped: the appendix was perforated about a quarter of an inch from its junction with the cæcum; it was tied at its base with a silk ligature, another suture secured the meso-appendix, and the appendix was cut away. The peritoneal cavity was *not flushed out*, the wound was left open and five gauze drains among the coils of intestine ensured thorough drainage. The patient's general condition during the operation was very grave, his pulse at one time was imperceptible, and strychnine, five minims, had to be given, no hope of his recovery being entertained.

During the night of September 21st the boy's condition was very bad, at times his pulse was irregular and feeble, at others it was imperceptible. Strychnine was



freely given and ether, minims 20, on two occasions had to be injected. Three eight-ounce hot port wine and coffee enemata were given and retained, and three axillary infusions, each a pint in quantity, were administered, two of these were of a ·9 per cent. saline solution and one of a 5·8 per cent. solution of dextrose, which last was slowly absorbed. By 8 a.m. (September 22nd) the patient had rallied. Strychnine was reduced, minims 3 being ordered two-hourly. Caffeine, 2 grains, with sod. salicylate 1 grain dissolved in a few drops of water was ordered four-hourly, subcutaneously, to induce a free action of the skin and kidneys. The boy was only allowed sips of hot water, vomiting being troublesome. Later the vomit became biliary, so large drinks of water were allowed; these gave relief by clearing the stomach of its foul contents; but as the vomiting again became more marked, all fluid by the mouth was omitted. Towards evening the vomit became black in colour, although not fæcal in odour. The patient was sat up in bed but without effect. The bowels had not been opened since the operation. Calomel and mag. sulph. by the mouth proved useless owing to the sickness they at once induced, and enemata of soap, oil, and turpentine were of no avail. In the evening a fourth infusion into the axilla of a pint of saline guarded against any risk of collapse. At 9 p.m. the boy was given chloroform and the wound dressed. The gauze drains were removed the wound appeared quite healthy, and there was very little discharge; as the abdomen was rather full and the coils of intestine distended, one ounce of a strong solution of mag. sulph. was injected into the exposed loop of intestine. During the day the boy's general condition improved, his pulse becoming full and stronger.

September 23rd. At 12.30 a.m. the patient's bowels were suddenly well opened. As the danger of paralytic distension of bowel was thus over and the boy had had no sleep since the operation, all treatment was omitted. During the twenty-six hours from admission the patient had sixty-five minims of the Liquor Strychninæ Hydrochlor. hypodermically. As soon as the bowels were freely opened the boy became restless, and at 1 a.m. he was delirious, trying to get out of bed; he was given one-sixth grain of morphine tartrate subcutaneously and by 2 a.m. he was quiet and he dosed off during the night. At 7 a.m. the vomiting was less and no longer black; he was given a ten-ounce rectal injection of a ·6 per cent. salt solution, which was retained. At 11 a.m. the sickness had ceased, and from this time the patient rapidly improved, a mild diarrhœa being maintained. The wound was partially closed nine hours after the operation and this led to a slight rise of temperature, which settled down in a few days to normal. On the eighth day after the operation the boy was on a meat diet and he was discharged cured four and a half weeks from the date of admission, no complications having occurred.

The chief interest of this case lies in the fact that it was regarded on admission and at the time of operation as utterly hopeless, and yet recovery took place in spite of the fact that the abdominal cavity was not washed out. Mr. Lane treats those cases where there is no foul-smelling pus in the abdominal cavity by incision and drainage, and flushes out the abdomen only when the pus is offensive.

K. BLACK.

In Lighter Vein.

QUITE-SO QUIDDITIES.

"The cat that talked to a crowd."

(With apologies to Mr. RUDYARD KIPLING.)

Once upon a time, Oh Best Beloved, there lived in the Medicine School, by the great, grey, greasy, Thames-river, a pussy cat; and know, Oh Best Beloved, that it was a docile and kind Pussy and it would let you talk to it and stroke it, and its head was not too big for its body, and its hat was just like your hat or mine; but that was a most 'stonishing long time ago, before the things I am going to tell you about became and befell and behappened.

Pussy grew very fast, Oh Best Beloved, much faster than all the other animals and at last he went into the great-dark-utterly-uninhabited-interior, and came back with lots of signs that the Magicians, who live in the great-dark-utterly-uninhabited-interior, had put after his name, and the Head-Chiefs made him H.-P. (that's magic), and after that the Head-Chiefs met and said, "We are exceedingly gratified with the excellent services that our young friend has rendered us, and would reward them fittingly." (That is the way all Head-Chiefs always talk.) And they said "He shall be a Head-Chief like us, and shall rule those who drive the pen." (Thats most 'sclusive-'stonishing-special-magic). And then Pussy stopped growing, least his body did, but his head grew most 'stonishing fast, so fast that his neck could'nt grow so fast, and so a hole got formed between his head and neck at the place where they join, Oh Best Beloved, and when it became and befell and behappened, that he talked to the crowd, most of what he said came out of this hole. Now hear and attend and listen, Oh Best Beloved, for when the Pussy knew that the Head-Chiefs had by their most 'stonishing-special-'sclusive-magic made him a

Head-Chief, he put on his hat, from which the rays of the sun were reflected with-more-than-oriental-splendour (all Head-Chiefs always wear hats like that), and went to see those who drive the pen, and when he found them he talked to them immediately, and directly, and without stopping and for a long time, and he said, "Oh my enemy and brother of my enemy, I will make you do blood-counts (that's magic) on every patient." He said lots more, Oh Best Beloved, but it all came out of the hole where his head joins his neck and so it didn't count. And then he took off his hat, from which the rays of the sun were reflected with-more-than-oriental-spendour, and went away singing the following sloka (which is magic):—

"The pen man that fakes
The blood counts he makes,
Courts dreadful mistakes."

He then went to collect his crowd. And, Oh Best Beloved, it was a most 'stonishing-'sclusive-big-crowd, and he took them into the wards (that's magic) where the Head Chief's Sisters live, and the Sisters said, "The noise of the feet of your crowd is like the footfall of an army, even the First Head Chief couldn't have collected such a big crowd so quickly. You must be wise!" And Pussy Purred, and talked to his crowd and was very happy.

And so, Oh Best Beloved, ends my tale.

JAUNDICE.

Sport.

Rugby Football.

GUY'S v. ROSSLYN PARK.

This match was played at Honor Oak Park on an ideal football day, before a large number of spectators. The ground was rather heavy after the long continued rains, and this somewhat interfered with good play.

Rosslyn Park kicked off and McEvedy returned well into mid-field, where a scrum was held. Guy's got the ball, but Jones's kick was charged down and smart following by Rosslyn Park nearly gave them a score. Though they got possession in the scrum their backs mulled, and good play in the loose first by Saunders and then by Morgan transferred the game to the other end of the field. Here slow heeling lost Guy's a good chance. Our halves were overwhelmed, and as the forwards were slow in coming to their assistance, Rosslyn Park worked up the field only to have their progress stopped in good style by Harrison. Earle and Leyton were now prominent on the line out, and Louisson and Cutler put in some very useful tackling. After some poor attempts to get the ball away from the scrum, during which both Cutler and Louisson held on too long, Cutler eventually started a good rush, in which McEvedy, Jones, and Alcock took part. Alcock was pushed into touch near our opponents' goal line. A scrum followed from the line out, and though Rosslyn Park wheeled, Louisson smartly secured and passed out well to McEvedy, who made a dash for the line. He was collared just outside and from the scrum Mullins got over near the corner. A. Alcock failed at goal. Saunders returned the kick out and a scrum followed near the Park goal line. Slow heeling and poor passing by the halves again lost a good chance, but F. Alcock made some amends by running strongly, and Leyton securing the ball from a pass got over. The try was disallowed for a forward pass. In returning the kick out Harrison waited too long and was collared with the ball. Iliffe, Pinching, and Earle, however, came to the rescue with good tackling and saving. A scrum was formed, and the passing from it all along the line was of the high tossing variety, so that eventually the ball went over Morgan's head. A Park man secured the ball, but Morgan charged down his kick and nearly scored from it. The Rosslyn Park team now rallied and their backs came down the field with a fine passing rush. This was, however, stopped by fine tackling in turn by Cutler, Jones, Alcock, and Louisson. Good play in the loose by Pinching, Saunders, and Mullins carried the ball back again. Here Jones lost a good opportunity by passing behind Alcock. The passing among the backs at this time was very feeble—one ran across the ground for several yards and handed the ball to another, who repeated the performance, so that eventually, on one occasion, the ball ended up out of bounds about twenty yards behind where the scrum was held.

Half-time was called with Guy's pressing hard and leading by 3 to 0. Saunders restarted play and Guy's at once began to play with more vigour, though not with much more skill. A rush on the left of the line ended in Alcock's downfall. This was followed by a rush on the right, the ball coming so slowly across the field that Morgan was collared as soon as he took the pass. From a scrum, however, Cutler and Louisson got the ball away smartly, and Morgan got over. He converted his try. Following the kick out Iliffe and Archer put in some useful play, and McEvedy made a fine dash. A good opening was made by the halves for Morgan who again scored after a pretty run. Harrison failed with the kick. The Park kicked out and good dribbling by Pinching. Saunders, and A. Alcock, carried the ball back to their line. Jones here intercepted a pass and ran well. This was followed by a good rush by McEvedy and Morgan, which forced the Park. Our opponents came away now with a good passing rush. This was met by resolute

tackling by the three-quarters, and Harrison brought down King-Stephens, who ended up the rush with a strong run. Louisson put in some good spoiling work and was very active in getting round the scrum. From a pass McEvedy got the ball near half way, broke through in fine style and made the run of the day. He eventually beat the full back and scored. Morgan converted. The backs were now playing well, and McEvedy again cut through and passed to Jones who ran strongly and scored. Morgan again converted. Rosslyn Park made a last great effort, and from a rush, Treloat eluding our backs made a strong run. He was eventually overhauled by Alcock just under our goal. Guy's worked back a little, but the Park got a mark in front of goal. The kick, however, failed, leaving us winners by 21 points to nil. Team :—

GUY'S.—E. M. Harrison (full-back); E. Morgan, P. F. McEvedy, J. P. Jones, and F. Alcock (three-quarters); M. G. Louisson and F. Cutler (halves); W. J. Pinching, S. McK. Saunders, T. Archer, M. Earle, R. Mullins, T. B. Layton, A. J. Alcock, and O. Iliffe (forwards).

REMARKS.—Though the game was rather a walk over, still the play of our team was far from first-class, and the back division especially shewed considerable deterioration. Handing the ball from one back to another does not constitute effective passing, however pretty it may look, and unless our halves and three-quarters resume the straight running of a year or two ago we shall be sadly handicapped in future matches. In case it should be forgotten, as it seems to be, it may be as well to point out that the duty of halves is to make openings for the centres, who in their turn must do likewise for the wings. This cannot be done by running straight across the field and crowding the wings on the line, to say nothing of the time wasted in so doing. It is a golden rule of modern passing that unless a man can go straight towards his opponents' goal line he should pass at once or be collared where he is, and not play about running to and fro Another rule is that a man should pass to his centre or wing, as the case may be, when the latter is in a better position than the passer, and not when the passer has wasted time and got himself and everybody else into difficulties. A couple of years ago Guy's got a name as a good back team and has been trading on it ever since. To come to individuals. The halves were excellent in defence but very poor in offence. Both passed slowly and high, and both ran across the field, though Cutler was the greatest sinner in this respect—sometimes even running back—and no doubt caused Louisson to follow suit. The three-quarters again were excellent in defence but the attack was weak. Time and again Morgan and Alcock were collared as soon as the ball reached them, or else they were only able to run into touch. McEvedy was excellent and made many attempts to stop the cross-field tendencies. Jones also played a brilliant game, but he does not study his man enough when passing, and several times passed to a man who was already practically collared. Of Morgan it is unnecessary to speak, as he did what came his way in his usual style. One could not help thinking what he might have done had the passes come better, and had more openings been made. Alcock has lost a good deal of his old dash. He also was slow when in the passing line and delayed the others considerably at times. Harrison at full-back has improved on last season's play. His kicking this year is splendid. Of the forwards—Saunders, Pinching, and Archer were the best all through. Earle played a good hard game, and his tackling and line work were quite good. Mullins and Iliffe were very useful, especially in the open. A. Alcock and Layton on the whole were only moderate, and will have to put more energy into their play if they wish to keep their places. The forwards as a whole heeled badly, the ball always seemed to hang in the back of the scrum. They nearly always lost the ball on attempting to wheel, and their coming round to support the halves and their following up was slow. The line work, tackling, and dribbling, however, were very fair.

GUY'S v. KENSINGTON.

This match was played at Honor Oak Park on October 31st. Guy's won the toss and Kensington kicked off. Unfortunately they only had fourteen men. Our forwards got the ball in the scrum frequently and gave the backs plenty of chances. Our halves were running too much across the ground, and instead of our scoring we made no ground at all, the wing three-quarters being forced into touch. McEvedy made a good run through the opposing backs, but could not break down the Kensington defence. Both Morgan and Alcock attempted to drop goals, a minor resulting on each occasion. McEvedy hereabouts made another fine run, and passing to Jones the latter transferred to Alcock, who scored in the corner. Harrison made a fine attempt to convert. A little later Cutler with a straight run also scored in the corner. This time Harrison landed a grand goal. Half-time was called with Guy's 8 points, Kensington nil.

In the second half rain fell and made the ball very hard to handle. The halves were now playing much better. Morgan got a tug after all the backs had handled, but failed to convert, the ball hitting the upright. Alcock also scored in good position after a grand run by Morgan, no goal resulted. From a free kick McEvedy almost dropped a goal the ball hitting the goal post. The forwards dribbled well at times in this half, Saunders and Mullins being prominent, and a couple of minors came from their efforts. Towards the end, Morgan made a wonderful run dodging all through their team, but his pass when he reached the back was mulled. No side was called with Guy's 14 points, Kensington nil.

GUY'S 2ND XV. v. CATFORD BRIDGE "A."

Played at Honor Oak, and resulted in a win for Catford Bridge by 1 goal 3 tries (14 points) to 1 try.

The forwards are settling down, but were beaten by a smarter pack. At other points we were equally outclassed except at back, where Husbands played a very safe game. During the latter part of the first half we were pressing,

and eventually Burney, from a pass by Gibson, scored far out, but Bookless failed with the kick. They had previously scored a goal; in the second half they scored three times, the game ending as stated. Team :—

Guy's.—F. A. Husbands (back); H. G. Gibson, B. H. Palmer, J. S. Bookless, L. H. S. Burney (three-quarter backs); F. J. Cutler, T. R. Harvey (half-backs); C. E. M. Jones, R. Davies-Colley, O. G. Iliffe, L. H. Robinson, J. Nairn, B. Moiser, S. M. Wells, H. E. Alexander.

GUY'S 2ND XV. v. LENNOX 2ND.

Played on the L.A.C. ground, Saturday, October 10th. Being our first game, it was very ragged; the forwards hardly packed at all, the halves and back were good. Palmer scored for us during the first half and Willan converted. They scored far out during the second half, but it was not converted, and the game ended in our favour by 1 goal (5 points) to 1 try (3 points). Team :—

Guy's.—F. A. Husbands (back): H. G. Gibson, B. H. Palmer, H. F. Wight, W. H. S. Burney (three-quarters); R. Willan, F. J. Cutler (half-backs); R. Davies-Colley, O. G. Iliffe, W. H. Robinson, J. Nairn, S. M. Wells, H. E. Alexander, L. E. Williams, F. W. Hogarth (forwards).

GUY'S 2ND XV. v. KENSINGTON 2ND.

Played at Wood Lane on October 31st, and resulted in an easy win for us by 1 goal 5 tries (20 points) to nil. Although the ball was in rather a greasy condition the passing among the backs was good; the forwards played well, but there are one or two who think leaning against the scrum is quite sufficient. In the first half Burney scored three tries, but they were all far out and none were converted. Willan during this period was injured and had to retire. In the second half the forwards, ably led by Jones, had the ball out time after time, and Burney scored far out and later between the posts, the latter was converted. Wight scored. Team :—

Guy's.—F. A. Husbands (back); H. G. Gibson, H. F. Wight, B. H. Palmer, W. H. S. Burney (three-quarter backs); R. Willan, E. C. Myott (half-backs); C. E. M. Jones, B. Moiser, J. Nairn, W. E. Williams, L. L. C. Reynolds, F. W. Hogarth, H. E. Alexander, B. B. Metcalfe (forwards).

GUY'S 2ND XV. v. BOROUGH ROAD COLLEGE.

Played at Honor Oak Park on Wednesday, October 21st. The ground was in an extremely heavy state, and the ball became most difficult to hold. The packs were fairly equal in weight, but our opponents were much the cleverer with their feet, obtaining the ball and wheeling away nearly every time. At the end of the first half we crossed over leading by a goal to a try, our goal resulting from a try by Palmer, but in the second half they scored three times, converting on one occasion, and thus winning by 1 goal 3 tries to 1 goal. Team :—

Guy's.—C. H. Marshall (back); H. G. Gibson, B. H. Palmer, H. F. Wight, W. H. S. Burney (three-quarter backs); R. Willan and T. R. Harvey (half-backs); T. B. Layton, R. Davies-Colley, O. G. Iliffe, W. H. Robinson, J. Nairn, S. M. Wells, L. L. C. Reynolds, H. E. Alexander (forwards).

GUY'S 2ND XV. v. SURBITON 2ND.

Played at Surbiton on October 24th. We had a much heavier pack than our opponents, and they had the ball out frequently; the outsides took advantage of this and scored freely. From a punt across, Gibson secured the ball, and making a good opening passed to Wight, who scored far out. Wight soon scored again, and Burney added a further try, which was converted.

In the second half, as the result of good passing, the following scored :—Palmer (1), Wight (1), Burney (2), and Willan (1), the latter converted three times. Surbiton, by a forward rush, scored in the last few minutes far out, and we won by 3 goals, 5 tries (30 points), to 1 try. Team :—

Guy's.—F. A. Husbands (back); H. G. Gibson, B. H. Palmer, H. F. Wight, W. H. S. Burney (three-quarter backs); R. Willan and E. C. Myott (half-backs); C. E. M. Jones, R. Davies-Colley, W. H. Robinson, B. Moiser, J. Nairn, L. L. C. Reynolds, H. E. Alexander, F. W. Hogarth (forwards).

Association Football.

GUY'S HOSPITAL v. GUARDS DEPOT.

Surrey Senior Cup—2nd Round.

This match was played at Caterham on Saturday last, and resulted in a draw of one goal each. Guy's lost the toss and played uphill and against the wind. Our opponents immediately began to press and nearly scored owing to a misunderstanding between the backs. We had several corners given against us, but each time they were well checked. A good run by the right wing took the ball into our opponents' quarters, and Barber, getting possession, had no one to beat but the goal-keeper, but he brought off a magnificent save, and a corner was gained, of which nothing came.

Half-time arrived with a blank score-sheet. On re-starting, Guy's at once began to press, but could not penetrate the defence, until Litchfield getting possession went clean through and scored with a well-placed shot. Guy's continued to have the best of the game till a very unfortunate accident occurred. Rankine, in clearing the ball, fell heavily and had to be carried off the field with a fractured leg. From this point Guy's acted entirely on the defence, but five minutes before time the Depot scored from a rebound from the cross-bar, and the match ended as stated. The tie will be replayed at Honor Oak Park, Saturday, November 21st. Team :—

Guy's.—E. A. Collins (goal); K. G. Jones, L. E. Rankine (backs); L. H. Frankenberg, H. F. Dening, P. Pedrick (half-backs); G. Wrag, G. C. Litchfield, H. Barber, A. F. Wearing, S. A. Piper (forwards).

REMARKS.—The forwards did not shew such good form as in previous matches. This was probably due to the state of the ground, the grass being thick and long, which effectually prevented good combination. All the halves played well, particularly in defence. H. Jones, at back, was not quite up to his usual form; it must be remembered that during the first half the sun was in his eyes and that he was partnered by a man playing out of his place after Rankine's accident.

United Hospitals Hare and Hounds.

O. S. Norton (Guy's) has been elected Captain, vice G. A. Symonds (St. Thomas's), who has been compelled to resign on account of Hospital work.

The following fixtures have been arranged up to Christmas:—

Nov.	21	v. Ranelagh H....	Putney.
	28	v. Thames H. & H.	Roehampton.
Dec.	5	v. Blackheath	Blackheath.
	19	Inter-Hospital Cup Race ...	Blackheath.

The following are the probable fixtures and dates during the remainder of the season: —

1904.

Jan.	16	Handicap	Blackheath.
	30	v. Dublin University	Blackheath
Feb.	13	v. Oxford University	Oxford.
	20	v. Wellington College	Wellington.
Mar.	12	v. Lancing College	Lancing.

MATCH v. SOUTH LONDON HARRIERS.

This was run over the South London Harriers' Five-mile Course at South Croydon on October 24th. With only one of last year's regular men available and Pilbeam running untrained, we had a very weak team, and our opponents, who though not quite at full strength yet put a very good set of men into the field, easily reversed last year's verdict, defeating us by the maximum number of points. Placings and times:—

		Mins.	Secs.
1.	A. S. Maples, S.L.H.	30	19
2.	P. A. Casserley, S.L.H.	30	20
3.	F. A. Knott, S.L.H.	30	30
4.	H. T. Blackstaffe, S.L.H.	30	30⅖
5.	A. L. Candler, St. Bart.'s	30	37
6.	W. H. Warner, S.L.H.	30	51
7.	T. E. A. Carr, Guy's	32	1
8.	F. Sanders, S.L.H.	32	11
9.	A. W. C. Thomas, S.L.H.	32	29
10.	W. Cunningham, Junr., S.L.H. ...	33	9
11.	E. L. Pilbeam, Guy's	33	29
12.	H. Stott, Guy's	33	35

S. L. H.—10 points. U. H. H. & H.—26 points.

The South London Harriers very kindly gave the team the usual feed and good time after the race.

Meeting of "Blues" Committee.

At a meeting of the "Blues" Committee on Friday, November 13th, the following men were awarded "blues":—

RUGBY FOOTBALL.—S. M. Saunders, G. Pinching, A. M. Tolhurst.

ASSOCIATION FOOTBALL.—A. G. Jones, A. W. Berry.

CRICKET.—A. B. O'Brien, H. D. Wyatt, L. G. Davies.

TENNIS.—F. W. M. Palmer, A. Zorab.

ATHLETICS.—E. L. Pilbeam.

An order to obtain the "Blue" may be had on application to Mr. F. J. STEWARD, Hon. Sec. Clubs' Union.

From the Gazette's Special Pathologist.

NOTICES.

G. M., HERTFORD.—This specimen is extensively infiltrated with branching processes of squamous-celled epithelioma.

C. L. H., BARMING HEATH.—Blood serum, inoculated with this swab, gave after incubation a culture containing micrococci and a few rod-shaped organisms arranged in chains, but no Klebs-Loffler bacilli were found.

PATHOLOGIST.

Special Notices.

GULL STUDENTSHIP IN PATHOLOGY.

In our last issue we note a mistake in connection with the announcement of the above studentship. Applications should be addressed at the Offices of the Medical School not later than Wednesday, December 2nd, and not December 22nd as previously announced.

Dr. LAURISTON E. SHAW has been re-appointed Honorary Secretary to the Faculty of Medicine in the University of London for the ensuing year.

Births.

BETT.—On November 8th, at 9, Cumberland Terrace, Regent's Park, the wife of Staff-Surgeon W. Bett, R.N., of a son.

ROWLAND.—On October 14th, at Western Elms Avenue, Reading, the wife of E. W. S. Rowland, B.A. Cantab., M.R.C.S., L.R.C.P. Lond., of a son.

Marriage.

TURNER-MAHOMED.—On October 23rd, George Albert Turner, M.B., D.P.H. Aberdeen, Medical Officer for Kimberley, South Africa, to Nellie Mahomed, daughter of the late Dr. F. A. Mahomed, formerly Assistant-Physician to Guy's Hospital.

ED.—R. E.

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Calendar of Coming Events.

December, 1903.

Sat. 5.—Messrs. Symonds and Steward's take-in; Drs., A. Leeming and R. Felton; Cl., F. H. Wallace.
1 p.m., Clinical lecture by Dr. Taylor.
G.H.R.F.C., I., v. Northampton, away.
II., v. Old Millhillians, home.
III., v. Old Blackheathens, away.
G.H.A.F.C., I., v. Tunbridge Wells, away.
II., v. Alleyn 2nd XI., home.
G.H.P.P.S., Paper by Mr. K. Black on "The Relation of Dental Caries to Disease."

Mon. 7.—1.15 p.m., Clinical lecture.
Exams. for M.D. and M.S. Lond. begin.

Tues. 8.—January Appointment List closed.
Exam. for B.S. Lond. begins.
Mr. Rowell's Demonstration on Anæsthetics, 12 noon.

Wed. 9.—1.30 p.m., Clinical lecture.
G.H.R.F.C., II., v. St. Thomas's "A," away.
G.H.A.F.C., I., v. Wellingboro' Masters, away.

Thur. 10.—Messrs. Lucas and Lane's take-in; Drs., H. M. Clarke and S. Wells; Cl., E. G. Goldie.

Sat. 12.—1 p.m., Clinical lecture.
G.H.R.F.C., II., v. Kingston, away.
G.H.A.F.C., I., v. Kenley, home.
II., v. Surbiton Hill II., away.

Mon. 14.—1.15 p.m., Clinical lecture.
Cambridge 1st and 2nd, and part I. of the 3rd M.B. Exams. begin.

Tues. 15.—Mr. Rowell's Demonstration on Anæsthetics, 12 noon.

Wed. 16.—1.30 p.m., Clinical lecture.
G.H.A.F.C., I., v. Sanatorium, away.

Thur. 17.—Messrs. Golding-Bird and Dunn's take-in; Drs., L. Doudney and R. P. Lewis; Cl., J. Goss.
G.H.C.U., Address by Dr. Lankester, M.D.

Fri. 18.—4.15 p.m., Meeting of Dental Society.

Sat. 19.—1 p.m., Clinical lecture.
G.H.R.F.C., I., v. Richmond, away.
II., v. Old Merchant Taylors II., home.
G.H.A.F.C., I., v. South Eastern College, home.
II., v. Emeriti II., away.
G.H.P.P.S., Debate.

Guy's Hospital Gazette.

DECEMBER 5, 1903.

Some Cases of Ulcer of the Tongue.

CLINICAL LECTURE BY R. CLEMENT LUCAS.
October 27th, 1903.

GENTLEMEN,—Two rather rare cases of ulceration of the tongue came under my care in Lazarus ward last week, so I thought it would be well to found a clinical lecture upon them. One of these was a case of primary chancre of the tongue, which I believe has been shown at the Physical Society, and perhaps it has been seen by a good many of those present. It is an exceedingly rare condition, and especially rare, I am happy to say, in this country. So much is that so that in all my experience, spreading over something like forty years, this is only the second case of it that I have had the opportunity of observing. The other tongue case, which was brought into the ward on the same day, is also a somewhat rare affection, though I think not so rare as it is usually regarded because it is often not diagnosed. It is tubercular ulceration of the tongue. I have seen a good many of those cases, and I have one under observation at the present time, besides the case I am alluding to, of which I have a few notes by Mr. Faulks.

To first describe the chancre of the tongue, I have a very good report here made by Mr. Eyles, my ward clerk. The patient is a man æt. 35, married, with a family, and I think it was his wife I saw when he came up. He has a remarkably strong family history; his father and mother are both living, and there were as many as three brothers and six sisters, one of

whom died of rheumatic fever. There is no reason to suppose that this man had anything but a strong constitution, and that what he is suffering from on his tongue is a purely accidental occurrence in a very sound and healthy man. He has had a little rheumatism at times—most of us have had that—and he complains of a little chronic stiffness in one elbow. He said that about five weeks ago he noticed a couple of little spots just under the tongue, on either side of his frænum; and as they grew larger he consulted a doctor, who gave him some medicine which did him no good; and last Saturday week, October 10th, he came to the hospital and was seen at Out-patients. He then had a sore of considerable size situated on the under surface of his tongue, and spreading forward from the frænum towards the tip. He had had some headache, which he attributed to this. Whether it was that or whether it was the medicine he was given, I do not know. One can scarcely associate an ulcer on the under surface of the tongue with anything but a neuralgic affection, and therefore his headache was probably attributable to some other cause. The patient cannot account in any way for the ulcer, except that "in his shop the men are accustomed to smoke the first pipe they see lying about." That is a sort of confession of sociability of a kind which, in perfectly healthy surroundings, might not lead to much ill result, but I think it led this man to become inoculated with syphilis. When I speak presently about tubercular ulcer I shall also allude to a case which I think was brought about by that usual, but not very satisfactory habit of putting pens in the mouth when not actually using them in writing. The situation of this sore on the under surface of the tongue is where a pipe would readily touch, or a pewter pot or glass out of which he might have been drinking may have touched a surface which was ulcerated or abraded accidentally. The report goes on to describe the condition. Beneath the tongue, on each side of the frænum, is a shallow ulcer, almost symmetrical. The ulcer extends from about half way back almost to the tip of the tongue. The edges are slightly undermined, but there is no nodulation. The ulcer is very painful on biting, and when food gets under the tongue. It has a bad smell, and is greyish in colour, the surrounding parts being slightly inflamed. Beneath the jaw on the left side the glands are swollen and joined together. This swelling extends from the symphysis to almost the posterior border of the ramus. It is not in the least tender, and there is no fluctuation. The glands are somewhat hard to the touch, the skin is not adherent or broken. The glands seem adherent to the deep parts. The pain on touching the ulcer seems to shoot along the nerves, and lasts for a few seconds. It is almost unbearable while it lasts.

Looking at this sore, and seeing the healthy man that he was, as well as the thickened surface round about it and its greyish surface, I at once suspected, as others had done before, that he was suffering from syphilis. My house-surgeon told me the sore had been there five weeks, and I said, "I suppose it is a little early for the rash, is it not?" He said, "No, I think I have already found some spots upon the body." So possibly five weeks is not the correct period, as the rash was well developed at about this date. Six weeks to two months is a more common period for the appearance of the rash from the time of inoculation. If there has been nothing to fix the date of inoculation in the man's mind, he is apt to be a little indefinite on the point, and the reason you get an exact date given in the case of chancres of the penis is that the man is able to tell you he had connection on such and such a day and on no other. It frequently happens, however, that no ulcer is noticed on the penis until some two or three weeks afterwards in true Hunterian chancre; whereas a soft sore is noticed much earlier. A slight abrasion takes place with inoculation in true syphilis, which does not harden or form a definite lump until two or three weeks afterwards. The facts, therefore, that the man has this definite sore under his tongue, that he has distinctly large glands under his jaw, and a brownish macular eruption over his arms and body make it quite clear that he was inoculated with syphilis in that situation, and that he is now suffering from the secondary effects of it, the primary sore being still there, and of a definitely large size. The appearance of a

syphilitic sore varies very much with its situation. This sore under the tongue is not nearly so definite in appearance as it would have been if the inoculation had occurred on the surface of the tongue, or at the edge, where the epithelium is thick, for then the heaping up of the thickened tissue is much more characteristic. I have seen a case of Hunterian chancre on the knuckle in an old man who used to attend midwifery cases—an unqualified practitioner who was admitted into this hospital under my care. There was a large ulcer over his knuckle with a very thick edge. A drawing of it is to be found in the museum. Where the cuticle is thick, the heaping up of the tissues is much more evident than where it is thin. I do not know that I need go on to say any more about this particular primary chancre of the tongue. The way in which it was caused seems quite clear, and it suggests how careful one ought to be as regards instruments which may carry infection. That, I think, applies especially to dentists who, like surgeons and obstetricians, are themselves liable to be inoculated with syphilis. Our former dental surgeon, Mr. Moon, was inoculated on his finger. I remember the chancre exceedingly well, and the trouble it caused him. It was really the cause, eventually, of the loss of his life, for this inoculation of syphilis so preyed upon his mind. And while speaking of this I may say I cannot think that the latest memorial here, the drinking fountain, which has been put up in the colonnade, is altogether free from the suspicion that it may be a means of distributing the syphilitic virus. I only mention this to show how careful one ought to be in neighbourhoods such as this, where syphilitic persons are constantly visiting the hospital, with their mouths often affected with the disease.

I stated that I have seen only one other case of primary chancre of the tongue, and that was in one of the most respectable men in the City of London, a senior clerk in a Life Assurance Office with which I am professionally connected. I am bound to say I failed to make a diagnosis the first time I saw him; I never dreamt of his having a syphilitic ulcer on his tongue. He told me he had a little bothering sore on his tongue, which he asked me to look at, and I found immediately opposite this sore a broken gold plate, with a sharp, cutting, pointed edge, where one of the false teeth had been broken out. I thought that was quite sufficient to account for the sore, and I told him to take out the plate and leave it out until the sore got better. I gave him some simple chlorate of potash lotion, and told him it would soon be quite well. I was asked to see him again a week or two afterwards, and then, instead of the sore having improved at all, it had evidently extended, and around the small sore which I saw at first was now a very definite thickened edge. Then I noticed that under his chin was a very much enlarged gland, and now I began to have other suspicions. Was it epithelioma? Then, as I looked him over, I thought I saw a little spot on his forehead, and I asked him if he had any more. He said yes, he found some on his arm that morning. I found he was suffering from secondary syphilis, and that this was a primary chancre on his tongue. I am not sure whether he smoked, but my idea was that there was a sore produced by the dental plate, and—he was a clubby sort of man—that this was brought into contact with some drinking cup which was infected. I treated him in the usual way, and he is now alive and well, though it must be nearly twenty years ago.

That leads me to say a few more words about syphilitic ulcers of the tongue. This was a primary syphilitic ulcer, but there are many others met with in association with syphilis. There is secondary ulcer of the tongue, which is a surface ulceration appearing in the secondary stage, when the rash is out, and when the sores attack also the soft palate and tonsil. You look in his case for the symmetrical sores which have been described as like two kidney-shaped sores, one on either side of the uvula. You also look for ulceration about the throat and tonsils. The little oval or roundish ulcers on the side of the tongue, and the greyish surfaces where the teeth irritate, are very much aggravated and kept up by smoking. They are also kept up by the too free administration of mercury. These conditions, especially if the man is negligent of his teeth and allows tartar to accumulate on them

and has one or two broken, bring about a chronic glossitis. This leads to those scar-thickened, peeling white tongues, which have been variously described as leukoplakia, leucoma, ichthyosis, psoriasis, and the like. It may get exaggerated into this great thickened white surface for which I suggested the name psittacosis. Here I show you various drawings of tongues. One shows an ulcer with a certain tendency to scarring; another where the tongue is all puckered up from old cicatrices, the epithelium being in some places denuded, and in others greatly thickened. Therefore, I want to impress upon you the importance of compelling a man to give up his smoke when you are treating his secondary syphilis; and tell him to be careful about condiments in his food. Also see that his teeth are well kept, that there are no angles and points pushing against his tongue; and then, with simple treatment, you may hope the whole thing will subside. When chronic glossitis, from secondary syphilis, has existed for many years, there is a great proneness to the development of epithelioma, so that a life may be sacrificed through neglect of these syphilitic tongues.

The only case of this kind I think I have had —certainly the only one I have had in private practice—in a female, was that of a woman who had been infected with syphilis at her marriage about twenty years before. From that time onwards she had always had a thickening of epithelium on her tongue. When I saw her she had a distinct epithelioma of the tongue with enlarged glands in the neck. I had to remove that tongue. The impression I wish to convey to you is that epithelioma of the tongue is very uncommon in women. So also is epithelioma of the lip, which is nearly always associated with the use of pipes. There is also a form of syphilis which is a superficial ulceration spreading in a circinate manner. That was described by Parrot, a Frenchman, who pointed out the symmetrical nodes on the surface of the skulls of infants who were affected with hereditary syphilis. In this country this sign (the circinate sore) is not universally accepted as indicating syphilis. Undoubtedly it is sometimes found in persons in whom there is no reason to suspect syphilis has been inoculated. But I think I should always regard a circinate eruption on the tongue of an infant as being very suspicious of hereditary syphilis.

Finally, we come to the gummatous form of syphilis of the tongue, the late stage of syphilis after the secondary stage has passed away. It may occur may years afterwards; *i.e.*, when the person is depressed in health he is liable to these gummatous swellings. Why they should occur on the tongue in one person, on the knee in another, or on the chest wall, or attack a bone, it seems very difficult indeed to determine. Whether there is any injury which determines the breaking out of the syphilis in that part I am unable to say, but these gummatous ulcerations are sometimes, in their appearance, so like epithelioma that confusion is apt to arise. It is, therefore, very important that you should be able to distinguish between epitheliomatous ulcer and ulcer depending upon tertiary syphilis. I will, therefore, go over the principal points with regard to these two conditions. It is a very common examination question. First of all, I will speak of syphilis, and take the gummatous form. If you get a definite history—which is not always easy in the people subject to these diseases, hard-working people who think very little about a small sore or swelling—you find that in all these cases of tertiary sloughing deep ulcers of the tongue there is a history of there having been a lump in the tongue. Sometimes there is a history of more than one lump in the tongue, the biggest one of which sloughs and forms an ulcer. And you find, perhaps by the side of it, another lump which is not ulcerated. If you find two lumps on the tongue, and they are on the dorsum and rather far back, you will take into consideration the possibility of its being a tertiary syphilitic affection rather than cancer. Epithelioma commences almost invariably on the side of the tongue, and is very frequently associated with some chronic irritation, due either to bad or irregular teeth, or to a pipe, or to the accidental rubbing of the tongue against some instrument which the man is in the habit of carrying in his mouth. But it almost always commences as an ulcer, not as a lump. But in a few cases the man tells you

he first noticed a little lump on the side of his tongue, which was probably thickened granulation tissue, which he would not regard as a sore. From this you get a thickening spreading deeply in the substance of the tongue, the surface ulcerates more and more deeply, and gets pouched and bad smelling. The tongue gets bound down in the mouth, so that it is difficult to move it, and the glands in the neck become enlarged. With gumma you get a history of a lump, a breaking down of that lump, and a sore. When it ulcerates, it leaves at first, where the ulceration takes place, a yellow, firm, so-called wash-leather slough; and if that gets cleared away you get a deeper ulcer and a more ragged edge, but with a redder centre than before. These gummata do not infiltrate the tongue deeply, and do not bind it down to the floor of the mouth. Epithelioma, during its progress, excites a great deal of pain and salivation, and when the man is unable to swallow comfortably, the saliva dribbles out of his mouth, the tongue does not move, he is in great pain, and the irritation of the surface of the sore excites salivation. In the gummatous form you get the history of a lump, the sloughing out of a deep ulcer; but the gummatous tongue nearly always moves perfectly freely. Very likely he gets enlarged glands below his jaw, and that you commonly find. They are not the hard glands which you find in epithelioma. And if you give iodide of potassium, the sore rapidly heals and the glands disappear. On the other hand, if you give iodide of potassium and mercury in epithelioma of the tongue, you rather increase the symptoms than do any good.

I pass now from a comparison of syphilitic and cancerous ulcers of the tongue to say a few words about tubercular ulcers. I have to thank my house-surgeon, Mr. Faulks, for the notes of this man, who was to have come into the hospital as soon as a bed was vacant, but did not do so. He is 42 years of age, married, a job-master by trade. He has lived very freely, and partaken largely of spirits, in which way he has probably weakened his power of resisting any infection he may be exposed to. Though we can learn no history of consumption in his family, he has probably led a loose sort of life, and drunk very heavily. Undoubtedly he is now the subject of tuberculosis. During the last year he has had some trouble with his chest, and is suffering from a slight, but persistent, cough. In reply to my question, he said he spat blood last winter, several times. He has also smoked a fair amount, but never a clay pipe. He has never had any venereal trouble. The ulcer on the surface of his tongue is of three months' standing, but it gives him no pain, except when he eats rough food. The ulcer is described as about the size of the top of a billiard cue, but I think cues vary in size. It is about one-eighth of an inch in depth, near the median line, and about one inch behind the tip. This sore has a greyish, pale, flabby look. If you pinch the tongue you may persuade yourself that there is a little induration round about it; but it has nothing like the heaped-up infiltration either of chancre or of epitheliomatous ulcer. Neither is it in the position either of a chancre, or an epithelioma; it is nearer the fore part of the tongue, on its dorsal aspect. This man said he had been suffering from asthma, and when his chest was examined he was found to have a tubercular cavity in the left lobe. So he has a combination of phthisis and tubercular ulcer of the tongue.

I will now relate to you another case. About fifteen years ago I admitted into Bright ward a gentleman who had been very much overworked in an office in the City. He came of a distinguished family, and was himself ambitious; and he worked at the high mathematical problems which men have to pass in who wish to qualify for the Institute of Actuaries. He desired to become an actuary in one of the Life Offices. He passed a very stiff examination, and was highly thought of. But his mother died of phthisis, and he was very delicate. He got an attack of influenza, and after that the glands on one side of his neck became enlarged, and showed no signs of subsiding. They remained large some five or six months, in spite of changes of air and general hygienic treatment. So I suggested that they had better be removed. An uncle of his was a very distinguished member of our profession, and he agreed with the wisdom of removal. I excised a large number of glands from the left side of his neck, right down to the

top of his clavicle. The wound healed primarily, but everyone of those glands contained caseous material. He progressed; was first made assistant actuary, and then took the full responsibility of the mathematical work of one of the principal offices in London. For ten years he remained in good health. In his more responsible position he had another attack of influenza, and again he broke down, looking ill and thin. He came to me and said, "I have a nasty little sore, that I cannot get rid of." It was situated near his last molar tooth and on the side of his tongue. It was a little white patch, with a pale surface: a flabby-looking, anæmic, granulating ulcer. I tried all kinds of things on this; I think I must have exhausted the Pharmacopœia in lotions. I also tried mild caustics; and this went on for months and would not heal. It used to bother him when he was eating and if he got any food there. Then we got the history that he was having little attacks of fever, and he said, "I can never clear off this influenza." He used to get a shivering fit in the evening, and perspire freely; but after a couple of days he would recover and return to the office. This happened over and over again, and he said, "I never got that influenza germ out of me entirely." Then one began to get suspicious that some morbid process was taking place. His lungs were carefully examined by a physician, but he could find nothing wrong with them at that time. I said I was of opinion that the ulcer on his tongue was tuberculous, and we began to think he had an extension of that condition along the glands of his neck into his chest, with a tuberculous involvement of the glands about his bronchi. After a long time this ulcer healed, but it was not due to any treatment that I administered. Why they should heal sometimes and not at others whatever you may do to them I do not know. Then he had a chronic cough, with slight expectoration. On one occasion this expectoration was caught and examined, and tubercle bacilli were found in it. He went slowly on; two winters he went abroad, and the condition of his lungs was one of emphysema, his chest was "drummy." We suggested that the tubercle was deposited deeply, and that there was an infection of his bronchial glands, the affection of his lungs having been secondary. Eventually he died after having been two years abroad.

There is another case I am now observing. In the same office one of the directors used to be frequently closetted with this man. He is about 64 years of age, and about two years ago he got a curious ulceration of one side of his tongue. Nothing that we did seemed to do him any good, and I did not like the look of it, because it had such a chronic course. Then I noticed a little gland behind the angle of his jaw, and two other little glands in the submaxillary region, about the size of very small marbles. He is a very careful man and was in the habit of taking a good deal of exercise in the open air. But things are progressing slowly, and I fear the condition may be tubercular, which was my earlier suspicion. I took out his false teeth, and made him go without a plate for a long time, but it did not seem to do any good. This summer he began to suffer from asthma, for which his medical man sent him on a journey, but he was worse away than he was at home. He has a husky cough, and seems to be going the same way as the other man. It is possible he may have got inoculated by using the same pens as the other man. So I fear this man has senile phthisis. Therefore, you will see that tubercular ulceration may be quite an early symptom, and that is what I want particularly to point out, because generally that is not recognised. These people go to a surgeon, who knows nothing about the lungs or anything of that kind—it would be absurd for him to know that such a condition as phthisis occurred in anybody who had ulcer; it is not expected of him; and so, perhaps, these cases are not recognised so early as they might be. In the majority of cases the ulcers occur in advanced phthisis, and are simply an additional manifestation of the condition.

I must now say just a word or two about the simpler ulcers of the tongue with which those we have been discussing may be confused. A simple ulcer of the tongue may be brought about by merely biting the tongue; and it may be kept up by a sharp tooth, or by an awkward plate. It is incumbent upon anyone seeing this to advise that a dentist be consulted, so that all sharp edges and irritating surfaces may be removed.

One of the best cases I ever had from a diagnostic point of view was where the ulcer was not on the tongue, but on the inside of the cheek, where there was an old sharp amalgam stopping, from which the tooth had in part broken away. Opposite that was a threatening looking ulcer, which had been there about six weeks. When I saw the old gentleman he was about to undergo an operation for epithelioma on the inside of the cheek. I suggested that before operating it would be well to draw that tooth, and see if any good came of it. I am happy to say he is still living, and that the ulcer healed soon after the extraction of the tooth; and he has not since had any suspicion of epithelioma. There are also described dyspeptic ulcers on the surface of the tongue, but these I must ask you to consult physicians about; I know very little about them. They are described as occurring in people with bad digestion and furred tongues, and heal by simple treatment, attention to the diet and to general hygiene. Lupus, which is also a tubercular disease, may spread from other parts, such as the lips or other parts of the face. This condition is not common on the surface of the tongue, and when it occurs it is nearly always associated with lupus of the palate and cheek.

Special Notices.

A Case of a Rifle Bullet in the Posterior Wall of the Heart.

The man, Max Muller, who is the subject of a bullet lodged in the posterior wall of his heart, and about whom much has recently been written in the daily papers, will attend in the Radiographic Department, on Tuesday, the 8th instant, at 3 o'clock. Will those who wish to view this interesting case kindly be present in good time, as it is desirable to make the exposure as short as possible.

E. W. H. SHENTON.

Papers by Guy's Men.

A Note on the Differential Leucocyte Count in Worm Infections. By A. E. Boycott, M.A., M.B., B.Sc. Oxon. *British Medical Journal.*—14th November.

A Case of Mediastino-pericarditis. By J. Lloyd-Roberts.—*The Lancet*, November 7th.

Two Clinical Lectures on Aneurysm of the Abdominal Aorta. By J. H. Bryant, M.D., F.R.C.P. Lecture II. —*The Clinical Journal*, November 25th.

In Lighter Vein.

"Gentlemen-Rankers out on the spree, etc., etc."

[On Wednesday, November 25th, about 40 of the Oxford and Cambridge men at present studying at Guy's Hospital, dined together at the Bridge House Hotel.]

Outspake the Chieftain famous
For Blood Counts White and Red,
"Saint Lymphocyte! A notion
Has come into my head!

An Oxo-Cantab dinner!
How grand a thing 'twould be!
How nice to foster friendship
'Tween Fresher and H.-P.!

Let us support Protection,
Nor glut the alien's greed;
They've French chefs at the Carlton,
In Southwark we will feed."

So to a modest hostel
Nigh London Bridge came Brown,
And Jones the Senior Wrangler,
And Smith who'd been "sent down."

United all as Guy's men,
From Isis and from Cam,
Sat down, no longer rivals,
The lion by the lamb.

To soup, and joint, and entrée
They justice quickly paid,
And finished up with speeches,
Their hunger once allayed.

One topic universal:—
"No common men are we,
What intellectual giants
To-night around we see!"

Their 'Varsities they toasted,
Voted each other bricks,
And all went home contented,
Well fed for four-and-six.

PULEX.

The Smoking Concert.

On Saturday last, in the College Dining Hall, was held one of the most successful "Smokers" of recent years. The three factors contributing to this happy issue were, firstly and chiefly, the presence of Dr. Stevens in the Chair. Rarely before have we seen a more orderly audience; and this was as much due to the respect evoked by the Chair, as to the excellence of the entertainment. Another reason for the frequently and forcibly expressed satisfaction, was the inimitable performances of Messrs. Edridge and Woodward, who severally and collectively provided as good fun as has ever been enjoyed at these concerts. Last, but not least, was the new talent, always welcome, but never so well received as on Saturday. We are very glad to welcome Messrs. Davies, Jones and Palmer to the unique "Guy's Smoker."

Pass List.

University of London, November, 1903.

DEGREE OF DOCTOR OF LAWS.—LL.D.

Harold Nolan.

Licence in Dental Surgery, November, 1903.

SECOND PROFESSIONAL EXAMINATION.

Parts I. and II.—R. Glendining, T. J. Green, B. H. Martin, F. N. Palmer, C. W. Randall, R. Roberts, C. D. Wallis.

Part I.—A. B. Cocker, *H. E. Collett, *A. Goodey, *W. J. Goodman, *G. Howard, *C. J. S. Kliszczewski, *A. L. Moon, J. A. Oates, *C. L. Palmer, *A. E. Preston, *W. R. Ransford, *W. S. Stevens, *E. White.

Part II.—S. H. Barlow, H. S. Chandler, *W. H. Elwood, *A. E. Holman, *F. H. Lennox-Jones, *H. C. Malleson, *S. H. Peatfield, *A. E. D. Prideaux, W. W. Vaughan, W. H. Yeo.

*Denotes completion of the examination.

FIRST PROFESSIONAL EXAMINATION.

Mechanical Dentistry and Dental Metallurgy.—A. Angell, A. Harris, S. D. Marshallsay, L. A. B. Moore, J. S. Vogwell.

Mechanical Dentistry only.—*W. E. Cook.

Dental Metallurgy only.—*A. R. Durant, H. J. Snowden.

*Denotes completion of examination.

NURSING NEWS.

Miss Gertrude E. Blower has been appointed Matron of the Gorleston Cottage Hospital, Great Yarmouth. She was trained at Guy's Hospital, and has worked as a private Nurse in connection with its Nursing Institution. She has also held the position of Sister at the Norfolk and Norwich Hospital.

Notice.

UNIVERSITY OF OXFORD.

Examinations for the Degree of Bachelor of Medicine, Michaelmas Term, 1903.

The Regius Professor gives notice that the Examinations for the Degree of Bachelor of Medicine will commence in the Examination Schools on Wednesday, December 9th, 1903, and that they will be held in accordance with the following time table:—

First Examination.

Wednesday, December 9th. Examination Schools. 2 p.m. Materia Medica.

Thursday, December 10th. Examination Schools. 9.30 a.m. Anatomy. 2 p.m. Physiology.

Friday, December 11th. Examination Schools. 9.30 a.m. Organic Chemistry. Chemical Department, Museum. 2 p.m. Practical Examination in Organic Chemistry, and viva voce.

Saturday, December 12th. Chemical Department, Museum. 10 a.m. Practical Examination in Materia Medica, and viva voce.

Monday, December 14th. Physiological Department, Museum. 10 a.m. Practical Examination in Physiology and Histology, and viva voce.

Tuesday, December 15th. Department of Human Anatomy, Museum. 10 a.m. Practical Examination in Human Anatomy, and viva voce.

Second Examination.

Wednesday, December 9th. Examination Schools. 9.30 a.m. Principles and Practice of Medicine. 2 p.m. Principles and Practice of Surgery.

Thursday, December 10th. Examination Schools. 9.30 a.m. Midwifery and Diseases of Women and Children. 2 p.m. Pathology.

Friday, December 11th. Examination Schools. 9.30 a.m. Forensic Medicine and Hygiene. Medical Department, Museum. 2 p.m. Practical Examination in Pathology, and viva voce.

Tuesday, December 15th. Radcliffe Infirmary. 9.30 a.m. Clinical Examination in Surgery. Written Reports of cases, and viva voce at bedside.

Thursday, December 17th. Radcliffe Infirmary. 10 a.m. and 2 p.m. Clinical Examination in Medicine. Written Reports of cases, and viva voce at bedside.

Friday, December 18th. Medical Department, Museum. 9 a.m. Practical Examination in Medicine, Surgery and Midwifery, and viva voce.

J. S. BURDON-SANDERSON,
Regius Professor of Medicine.

Further details can be found on the Hospital notice boards.

Passim.

The momentous Christmas week draws on apace, and already we begin to sigh for a breath of the Dickens' spirit to adequately describe the increasing bustle of preparation and the signs of the times. From the region of the Charities' room the tentative voice of the would-be Nigger is heard in the land, and already there is talk of costumes and "special business." The programmes of the respective concerts are made a matter of the closest secrecy, but rumour is as busy as ever and will have it that the decrease in the number of the concerts is likely to produce a corresponding increase in their quality. Quite the most typical sight at this time of the year is that of the importunate youth of the Boro' demanding from utterly irresponsible people a ticket for the Christmas Tea. We would warn all who may be replete with sympathy that at this time of the year "muvver" is always dead and "farver" is invariably out of work, that is according to the youth of the Boro'.

The arrangement of the Out-Patients' Tea is in most excellent hands, and subscriptions to the fund are earnestly solicited, both from sympathisers outside and also from those within the hospital. The first and second years' men are especially appealed to for help in this enterprise, as the demands made upon men working in the wards are so many, that they cannot in fairness be expected to help towards all. It does not fall to the lot of many junior men to be in Hospital at Christmas-time, and it may seem to them that they are subscribing towards a function about which they know nothing, but when they do spend their first Christmas up here, and pay a visit to Out-Patients' while the Tea is in progress, they will probably not be sorry that they took our recommendation on trust. Subscriptions can be sent to Miss Oxford, Sister of the Nurses' Institute, or to Mr. G. E. Malcolmson, Guy's Hospital.

We are indebted to the *Eastern Province Herald*, Cape of Good Hope, for the following account of the marriage of an old Guy's man:—

Yesterday afternoon, Staff-Surgeon C. M. Beadnell, R.N., of H.M.S. *Barracouta*, was married in St. Mary's Collegiate Church to Miss E. L. Bailey, by Canon Wirgman, D.D., Senior Chaplain of Colonial Forces and Vice Provost of St. Mary's, assisted by the Rev. Precentor Mayo. The aisle of the church was lined by the blue-jackets and marines of H.M.S. *Barracouta*, and the officers present were Commander Travers, Lieutenant Cardale, Lieutenant Hunt (who was best man), Engineer Lieutenant Gedge, Mr. Bruce Gardyne, midshipman, Mr. Hall, gunner, and Mr. Finch, artificer-engineer. The Rev. W. H. White gave away the bride, who was married in her travelling-dress. The scene in the church was brilliant with naval uniforms, and the blue-jackets and marines showed their appreciation of the popular Staff-Surgeon by chairing him after the ceremony and carrying him off to St. Mary's Rectory, from whence the wedding took place. It will be remembered that H.M.S. *Barracouta* was guardship at Port Elizabeth for a considerable time during the Boer war.

Staff-Surgeon Beadnell took an active part in the late Boer war, being mentioned in despatches on more than one occasion. It was for his distinguished services in South Africa that he received his promotion, and he took part in the triumphal entry into London of the *Powerful's* naval contingent in 1902. All who knew this distinguished Guy's man will congratulate him on his marriage.

Those responsible for the Oxford and Cambridge Dinner are to be heartily congratulated on their most successful revival of an old custom, that had been allowed to lapse into disuse. One of the greatest drawbacks of hospital life is the very great difficulty of maintaining at the same time anything like a normal sociable existence. There are, of course, many reasons why this should be so, and perhaps in the long run your really sociable man is not in any way handicapped by his temporary forced seclusion. However that may be, it is certainly well to preserve those few social interests that are extant and obvious, and in this attempt at realising afresh their union as a body, the 'Varsity men set an excellent example to all.

The *Middlesex Hospital Journal*, always an interesting publication, is this month still more interesting, containing, as it does, the report of an address delivered by Dr. Taylor to the Middlesex Hospital Medical Society. The subject

of the address was the "Study of Medicine," and those who have gone round the wards with Dr. Taylor, and still more those whose methods he has at times criticised, will readily admit his ability to deal with such a subject. We are tempted to quote freely from this lecture but refrain from doing so, for doubtless the passages would lose much of their meaning when torn from their immediate context. Quite incidentally the lecturer mentioned, that when you were the possessor of a telephone you soon realized that there were some messages better sent by post. What telephones had Dr. Taylor in his mind's eye?

The University of London continues its course with the energy, and also, unfortunately, the irresponsibility of youth. Some months ago, as we have already chronicled in these columns, one of its officials discovered that men who had passed the old Preliminary Scientific and went up for the new Intermediate Examination would be let off Organic Chemistry altogether. The authorities promptly decreed a special examination to meet the case; the syllabus of this examination was very properly to be identical with that of the old late Intermediate Chemistry and everybody has been diligently at work accordingly. In the current number of the *London University Gazette*, however, and little more than a month from the first of these special examinations, the authorities calmly publish a new syllabus, which as regards the practical work is much more extensive than the old one. These incessant changes are becoming more than a joke, and speak little for the foresight and discernment of the authorities concerned.

There are some small mercies to be thankful for, which may affect one or two of our men. Candidates who have already passed in Organic Chemistry at the Intermediate, but failed in other subjects, are excused re-examination, and those who failed in Organic Chemistry only, need only be re-examined in that subject.

There seems to be some doubt in the minds of those responsible for the wooden abomination which still rests above the mantelpiece in the Smoking-room, as to whether it really is as ugly as most people think, and whether it does not after all express so pretty a spirit towards those named thereupon, as to make any removal of it savour of ingratitude. If the old idea, that there is a spirit even in things inanimate, be in any way true, then the unhappy spirit of that board must have blushed repeatedly of late at the unstinted abuse of which it has been the object. It must even at times have dreaded personal violence from the ruder spirits, and even now there may still remain in its mind some doubt as to its ultimate fate. It is most necessary that there should be a permanent and graceful acknowledgment of the generosity of those who have so greatly benefited the Students' Club in various ways, but the general opinion is that it might be better expressed elsewhere, and in a different way.

The concert of the Guy's Hospital Nurses' Choral Society and Students' Glee Club is fixed to take place at 8 o'clock, on Tuesday, December 15th, in the Court Room. One of the chief features of the programme is to be the rendering of Macfarren's Cantata, "May Day," by the combined choir. Further particulars can be obtained from the notice boards in the colonnade and elsewhere.

The Physical Society holds a meeting this evening in the College, with Mr. F. W. Morton-Palmer in the chair. A paper will be read by Mr. Kenneth Black on "The Relation of Dental Caries to Disease." We should also like to call especial attention to this Society's meeting for December 19th, when there is to be a discussion on Cancer. The chair will be taken on this occasion by Mr. P. Blake-Odgers, who will introduce the subject. He will be followed by several speakers who will in turn discuss—Irritation as a cause of Cancer, Bacteriology of Cancer, Causes of Secondary Deposits and Recurrence, Embryonic Theory of Cancer and the Infectivity of Cancer. In view of the recent investigations into the nature of cancer and of the hopes expressed in some quarters as to its curability, this meeting should be one of the

most interesting of the session, and it is hoped there will be a large attendance.

The present football season has not been a particularly exciting one up to the present. Our 1st XV. have been doing fairly well, but the state of the ground has been against any great display of form. The team wants a dry ground and until now mud and rain have predominated. We are glad to see that the worth of McEvedy and O'Brien is recognised by the English Rugby Union, if not by the Irish. Both of these veterans were playing for the Universities and South of England against the West of England. Harrison also was reserve full back for the same match, whilst Morgan is again playing in the Welsh trials, and would seem to be certain of his International. In three out of four of the County matches played on Wednesday last, Guy's men figured prominently. So far as Hospital men are concerned, however, the main interest centres round the cup contests, and until these are played off there will be a wholesome sense of suspense, that should foster the keenness which can alone ensure the re-establishment of Guy's supremacy in the Rugby field. The outlook is distinctly hopeful, but there is a lot of room for improvement in the team as it now is; the forwards, especially, will have to buckle to if they wish to be anything like a powerful factor in the Cup matches, for at least two of our possible opponents possess a decidedly superior pack of forwards to our own. It is a backhanded compliment to any team to say that a game has been won by a brilliant line of three-quarters.

Change of Address.

Dr. M. Anslow Alabone has removed from 20, Lower Seymour Street, W., to 3, Biddulph Mansions, Elgin Avenue, W.

Surgeon J. H. Jones, R.N., H.M.S. *Mutine*, from the China to the Australia Station.

Dr. C. T. B. Maisey, from the Limes, Marden, Kent, to the Wilderness, Witham, Essex.

The Editor will be very glad to receive a postcard with notes of any change of address.)

Pupils' Physical Society.

A Meeting of the Society was held in the Smoking room on November 7th, at eight o'clock, under the chairmanship of Mr. P. R. Bolus. Twenty-five members were present.

A paper was read by Mr. G. Russell on "The Use and Limitations of Blood Counting," and was listened to with great interest.

Mr. Russell, in dealing with the variations and the nature of the red and white corpuscles in the blood in health and disease, reviewed the value of the results obtained for diagnosis, prognosis and treatment, and showed by short notes of actual cases, on the one hand, the great usefulness of accurate observation of the blood, and on the other, the dangers of conclusions drawn too hastily from such observations.

In the discussion which followed, Messrs. Goble, Blake Odgers, Bolus, and G. C. F. Robinson took part.

Mr. Bowen proposed a vote of thanks to Mr. Russell, characterising the paper as philosophic in range and unbiassed, and referred especially to Mr. Russell's treatment of the question of when to operate in cases of appendicitis.

Mr. Mollison seconded the vote, which was carried unanimously. The reader of the paper briefly replied, and the Society adjourned at 9.30.

THE USE AND LIMITATIONS OF BLOOD COUNTING.

Paper read by Mr. G. Russell.

Mr. Chairman and Gentlemen,—From early times the examination of the blood in disease has always been a study of the utmost fascination to students of medicine. Modern research and modern ingenuity have given unto us instruments and knowledge of which our predecessors never dreamed. What they lacked to aid them in their researches they amply gained in their skill and reasoning, and even in these modern times, with all our new inventions and with all our ingenuity, we can, in many instances, but confirm the views which our forefathers so skilfully outlined years and years ago.

Common sense pointed out that in the presence of disease the blood must obviously show, could they but detect it, some characteristic change. A morbid process, they argued, going on in the organism, must certainly affect in some way or other the vital fluid which nourishes and bathes its inmost tissues. They lacked, however, the many wonderful instruments which now have become commonplace objects enough to us, and so it remains for ourselves and our descendants to carry out the work which our forefathers themselves had to relinquish in their unequal struggle against disease. And when we come to think of it, there is hardly a disease known to us at the present time in which to our knowledge—imperfect, sadly imperfect though it is—there is not in the blood some recognized change. It may be a qualitative

hange, it may be a quantitative change—it may be both —or it may be a change which we can just detect, but detect and no more; nevertheless, a time, however, will surely come, and it may not perhaps be very far distant, when EVERY disease will have as part and parcel of its description an account of the pathological change which takes place in the vital fluid; and then, and then only, shall we be said to have made any notable advance in our blood research for knowledge to combat disease.

Reference to our modern therapeutics readily shows us the importance of such a knowledge. Take chlorosis for example. Research tells us that there is a lack of iron in the red blood corpuscles. It cannot as yet tell us the primary cause of such a deficit, but knowing by our examination of the blood that there is a loss of iron pigment, we can, by supplying the material lost, restore the patient to health, although we are ignorant as to the original cause of the disease. Again, in collapse from serious hæmorrhage, science teaches us that the loss of volume of the blood is the cause of the fatal syncope. Hence by intravenous injection of saline we replace the volume of blood lost, thereby saving the life of many and many a patient who otherwise would have assuredly perished.

Many other conditions could be cited, showing how important it is from a therapeutic point of view to have a thorough knowledge, as far as we are able, of the altered conditions of the blood in disease; it is, however, when we endeavour to regard the blood changes as aids in diagnosing the disease or diseases which produce such alterations, that we are beset with very great difficulties. If it did but happen that each disease produced a change in the blood for which no other morbid process could be responsible, then our task would be comparatively straightforward; but different morbid states unhappily produce similar changes—of a greater, equal or lesser degree—and it is in our endeavour to unravel the complicated tangle presented to us, to know what to accept as evidence and what to neglect, that we realise how uncertain are our methods, and how unreliable are our results.

For after all, it is not a matter to be lightly taken up or lightly put aside. Correct diagnosis means correct treatment, and correct treatment may mean a prolongation of life to the sufferer and a successful fight against his disease. The patient is the first consideration, and every means in our power should be used and welcomed to aid us in making a successful determination of his malady. But it is essential, seeing that the life not only of a patient, but also of a fellow creature, may depend upon a successful appreciation of his morbid state, to accept nothing as absolute evidence of a pathological condition unless it is derived from experimental data based on facts which time after time have been shewn to be unimpeachable.

Thus, by auscultation alone, we are able to definitely diagnose certain diseases and to definitely make statements as to prognosis, simply because we have a perfect comprehension of the pathological changes which have taken and which are taking place. Evidence, therefore, from which we make a diagnosis must be based on sound knowledge and sound pathology, we must ask ourselves this question.—Can we allow to influence our appreciation and treatment of a morbid condition evidence which we must admit is not based on sound understanding? Certainly not! And yet there are certain diseases whose natures are only recognisable by the aid of the hæmatocytometer. These are morbid processes which are actual diseases of the blood itself and the blood-forming tissue. In their recognition the hæmatocytometer renders us invaluable aid, but in conditions where the focus of disease is outside the blood I shall endeavour to show you how numerous, how complicated are the blood changes therefrom; I shall point out to you how colossal is our ignorance as to the actual cause of these changes; I shall argue that evidence dependent on such a basis is unsound; and lastly, I shall quote to you cases, which I trust will prove to you beyond all shadow of a doubt that the hæmatocytometer as a means of *absolute* diagnosis, save in circumstances which I stated a little while ago, is a danger both to our patients and to ourselves.

The Blood.

Now there are many ways of examining the blood, the chief of which are:—

a. Estimation of the number of red and white corpuscles and the percentage of hæmoglobin.

b. Examination of stained blood film in order to determine the relative proportion of different leucocytes and the presence of parasitic organisms.

c. Determination of the agglutinative power of the blood.

d. The bacteriological examination.

In this paper, however, the methods which concern us are the first mentioned, namely, the estimation of the relative number of red and white corpuscles and the percentage of hæmoglobin, and the examination of the stained blood film, which is as necessary in all white counts as the enumeration of the corpuscular element. The instrument which we use in determining the number of corpuscles is called a hæmatocytometer. There is no need to describe in detail the manner in which this truly wonderful instrument is used, because I know it is familiar to you all. It will suffice for me to say that a drop of blood of a known dilution is transferred to a counting slide and covered with a cover slip. On the surface of the counting slide, microscopic squares are ruled, each having an area of 1/400th of a square millimetre. The corpuscles fall into the squares and are counted under a microscope, and the number of red or white cells p. c. m. of pure blood are then ascertained. There is room for a great deal of error in such an estimation unless the investigator is skilled in the use of the apparatus. The present system which is adopted here leaves room for improvement. It requires a lot of experience to be able to perform a correct count, and one sees often hopeless differences between the results arrived at by the first three months' medical clerk and those obtained on the same individual by the second three

OVERHEARD IN MAZE POND.—A FACT.

SMALL BOROUGHITE: "If yer please, Doctor, will yer put moy nime and the biby's down for yer Kerismus Tree?" (N.B.—First Year's Man is immensely flattered and begins to realize what Guy's Christmas Festivities mean to the Borough children.)

months' medical clerk. At present the result of the blood examination is put in the report, irrespective of who performs it, and I feel certain that a great proportion of them are incorrect, and so worthless. I interviewed one of our house-physicians on the subject, and he said that he never believed in a blood-count unless he did it himself. If this method of assisting diagnosis is to be of any use there ought to be an official blood-counter to the hospital, like a bacteriologist, who would make all the necessary blood-counts and hæmoglobin estimations, while the ward clerk could make all unnecessary ones, thereby obtaining excellent practical experience. I feel sure that both the physicians and the house-physicians would then feel, that some reliance could be placed on so important an investigation.

Now before we can derive any information from the variations of the blood corpuscles in disease, we must be fully cognizant of their variations in health, and with this intention I will deal first with the red corpuscles, and then with the white variety, and endeavour to point out to you the alteration which they undergo dependent upon the state of health of the individual.

The average number of red corpuscles per c.m., as estimated by the hæmatocytometer, is 5,000,000 in the male, and 4,500,000 in the female. As a rule there is numerically but little variation either in health or, compared with the white corpuscles, in disease. We may divide the differences from the normal up in the following way:—

1. Health.—(*a.*) Conditions producing an increase above 5,000,000.
   (*b.*) Conditions producing a decrease below 5,000,000.
2. Disease.—(*a.*) Conditions producing an increase above 5,000,000.
   (*b.*) Conditions producing a decrease below 5,000,000.

I have laid myself open here to a definition of health, but I shall not attempt to define it. In the present classification by health I mean a state in which the individual feels perfectly fit and capable to perform his duties.

(*a*). Now we find an increase of over 5,000,000 red corpuscles p.c.m. in people who are accustomed to live in high altitudes such as in certain parts of Switzerland. It is invariably found that such persons possess seven, eight, or even nine million reds p.c.m. We also find an increase after violent exercise and cold baths, but this augmentation differs from the one I have just metnioned in being an apparent increase and not a real one. After a cold bath the peripheral circulation is supplied with red corpuscles at the expense of the systemic, so that the absolute increase is nil.

(*b.*) Causes of decrease below 5,000,000 compatible with health are practically nil. There is an apparent decrease after a hot bath but it only appertains to the peripheral circulation which is depleted at the expense of the systemic.

If we now regard alterations in the red corpuscular element of the blood in disease, I have divided them up into two conditions, the first of which is a gain in disease above the normal number.

Now such an increase may be a general increase, that is to say a real one, or it may only be apparent. A real increase is seen in any disease producing a general cyanosis, such as asthma, congenital heart disease, or any other heart disease causing an obstruction to the pulmonary circulation. In such cases the red blood count may be 8,000,000 p. c. m.

Again, in certain feeble subjects whose circulations are slow without being feeble enough to produce obvious cyanosis, we may find 6,000,000 red corpuscles p. c. m.

Lastly, in acute phosphorus poisoning there is a remarkable increase, a blood count as high as 8,650,000 having been observed, and in carbon monoxide poisoning an increase to 6,500,000 has been noticed.

Now there are also apparent increases in the blood estimation under the following conditions:—

(*a*) Local cyanosis, say of a limb, due to pressure of a tumour or other cause of obstruction on the vein. Here we find an apparent increase at the expense of the remainder of the circulation.

(*b*) Vasomotor disease, such as Raynaud's disease.

(*c*) After any loss of liquid in the body, such as diarrhœa, large and rapidly accumulating serous effusions, profuse sweats and persistent vomiting or starvation of liquids. All these morbid processes increase the red blood count by concentrating the blood, and therefore it is important that we should modify our ordinary methods of inference from the blood count under such conditions.

In a case of cirrhosis of the liver with ascites, there were 3,280,000 reds before tapping and twenty-four hours afterwards 5,160,000, a circumstance that might well be borne in mind.

Lastly, we come to the diseases where there is a decrease in the red blood corpuscles below 5,000,000.

Such a decrease is called an anæmia. It is here that the hæmatocytometer renders us invaluable aid and serves as an absolute means of diagnosis. In some cases it is not easy to diagnose an anæmic condition. A patient may be pale and yet the blood be normal, while again a patient may be of a ruddy complexion and yet on examination the blood will prove anæmic.

Anæmia may be arbitrarily divided into two classes, primary and secondary.

A primary anæmia may be defined as a form of anæmia of unknown cause and with but little pathological change to account for it. A secondary anæmia may be defined as a form of anæmia in which we can definitely recognise some pathological change to account for it. Chlorosis may be regarded as a type of the first class and the anæmia, say of renal disease, as an instance of the second.

Now, it is necessary in all anæmias to regard the estimation of the hæmoglobin percentage as as important as the diminution of the red blood corpuscles.

Hence three distinct types of anæmia can be distinguished :—

(1) A much greater reduction in hæmoglobin percentage than in the percentage number of red blood corpuscles, say reds 3,500,000 and hæmoglobin 25 per cent.

Here the colour index for one corpuscle is below 1. This is the chlorotic type.

(2) A very great diminution in the red blood corpuscles with relatively high percentage of hæmoglobin—say reds 1,000,000 and hæmoglobin 25 per cent. Index about 1.

This is the pernicious type of anæmia.

(3) A corresponding decrease of both hæmoglobin and red corpuscles—say 2,500,000 red blood corpuscles and 50 per cent. hæmoglobin.

This is a type of secondary anæmia.

Thus, by careful estimation a secondary anæmia can be distinguished from a primary.

For example, a man aged 40 was sent up by a local doctor as suffering from pernicious anæmia. He was exceedingly anæmic in appearance and was seized with dyspnœa on the least exertion. An examination of the blood revealed :—

Red blood corpuscles	...	...	3,750,000
Hæmoglobin	...	...	25 per cent.

This was obviously an anæmia of the chlorotic type, a form which is unknown in men, and the conclusion was that it therefore was a secondary anæmia. Careful re-examination of the man revealed a mass in the right lumbar region which at the subsequent autopsy proved to be carcinomatous

It is always well, therefore, to bear in mind that an anæmia of the chlorotic type occurring in a male patient is in all probability a secondary anæmia.

The causes of secondary anæmia are various. It may be due to :—

1. Inflammatory and febrile diseases.
2. Malignant disease.
3. Bad hygiene, pregnancy and lactation.
4. Intestinal parasites, such as anchylostomum duodenale.
5. Poisons, such as lead and arsenic.
6. Chronic nephritis, cirrhosis, dysentery.

Remember, though, that you may find two conditions in the same individual, one of them tending to increase the red percentage and the other tending to diminish it. For instance, chronic diarrhœa producing concentration of the blood, and therefore an apparent polycythæmia, may be associated with renal disease which is responsible for an anæmic condition, the net result of which is a seemingly normal state. Again, we can have a condition in which the same cause may give rise to two opposing conditions. For instance, epithelioma of the œsophagus, by reason of its malignant nature and perhaps the concurrence of hæmorrhage, is responsible for a certain amount of anæmia; but the starvation enforced by the dysphagia, provided there is one, will produce a concentration of the blood, and so an apparent increase in the number of corpuscles. Hence, the net result may be either an anæmia, a normal count, or a polycythæmia, dependent upon the amount of influence of each agent.

Having considered the red blood corpuscles in relation to disease and health, we must pass on to the white variety and deal with them in a similar manner. It is here that we meet with so much difficulty in deducing what is of value to us and what is not, and it is here that endless confusion arises because we have no sound basis for our arguments and thus are liable to grave errors.

The leucocytes of the blood are divided into several classes according to their appearance and reaction to various stains. We recognize the following varieties :—

1. Small lymphocytes.
2. Large mononuclear.
3. Transitional forms.
4. Polynuclear neutrophiles.
5. Eosinophiles.

You will notice that I have placed them in a certain order, beginning with the small lymphocyte and ending with the eosinophile. Now it has been thought that the various kinds of white corpuscles found in normal blood represent different stages in the life-history of one cell, namely the small lymphocyte. If we regard this cell as the youngest type of leucocyte, then the next stage will be that of the large mononuclear which is a more mature stage of the small variety. We then get various transitional forms until we arrive at the polymorphonuclear cell, which can be regarded as the adult white blood corpuscles, and which makes up the vast majority of the normal leucocytes of the blood. The eosinophile will correspond to the "over-ripe" cell, if we may call it that, and represents a stage further than the polymorphonuclear. We may regard it as the grand old man of the white corpuscles. It contains, like its predecessor, a polymorphous nucleus and granules, but the latter are larger, are coloured pink with eosin and present no constant situation in the cell, one time being on one side and again a little later being diffused all over the protoplasm.

The eosinophile is a warrior in every sense of the word; being by far the most actively amœboid of the blood corpuscles; when the ruthless bacillus invades his dominions, he is first on the scene of action, discharging his granules and scattering the foe. Then, when the time comes, his powder spent, unable longer to withstand the onslaughts of the legions of the enemy, he sinks and dies, thereby ending a tragedy which day after day is enacted in our blood, that we, the proud possessors of such valiant warriors, may add a few more years of existence to our lives.

The normal percentage of each variety is as follows :—

Small lymphocytes	...	...	20—30 per cent.
Large lymphocytes	...	...	4— 8 "
Polymorphonuclear	...	...	62—70 "
Eosinophiles	...	...	½— 4 "

In infancy the percentage of young cells, that is small lymphocytes, is 40—60 per cent., and the adult (polymorphonuclear variety) only 18—40 per cent.

Taking the average normal number of leucocytes in a healthy individual as 7,500, we find that this number is diminished or increased in health or disease. The change is estimated by means of the hæmocytometer, and from the data which it supplies we endeavour to diagnose or assist to diagnose disease.

An increase in the number of leucocytes above normal is called a leucocytosis, and a decrease below standard a leucopenia.

We are here confronted with a difficulty. It is all very well to say that there is a normal leucocytosis of 7,500, but for practical purposes such a fixed standard is not only useless but misleading. We have to regard the individual. For instance, in persons who are perfectly well but of a feeble disposition, their normal number of leucocytes may only be 3,000 p.c.m. In such cases a leucocytosis of 10,000 would most certainly be pathological. And again, there are many individuals of a vigorous constitution where the number of white cells rarely falls below 10,000. Thus, it is obvious that we must regard these differences in definition as well as practice, if we are to endeavour to reason at all correctly from data supplied by examination of the blood. We cannot go up to a patient, examine his blood and say that because he has has 7,500 leucocytes p. c. m., therefore no leucocytosis is present. It would be absurd, because such a person may have a normal leucocyte count of 10,000 or 3,000.

There is another factor of importance that must be mentioned, and that is age.

In children, the polymorphonuclear element is but twenty-eight to forty per cent., in adults, sixty to seventy per cent.

We must lay stress upon the varieties of leucocytes whose increase constitutes a leucocytosis, for, given a leucocytosis of 60,000 we are unable to say, without a differential count, whether the blood before us is derived from a person suffering, say, with pneumonia, or from a patient with leukæmia.

You can see that on such a vague foundation, and with such a vague standard, how it is that we can have no absolute judgment. We must first regard the individual and regard the number of his leucocytes as a measure of the vigour and stability of his metabolism. If one is to practise amongst all sorts and conditions of men we may expect to find their normal leucocyte count to vary between 3,000 and 10,500. Our definition of leucocytosis must embrace all these facts and conditions, and that laid down by Cabot seems to meet all these requirements. His definition of leucocytosis is as follows—"An increase in the number of leucocytes in the peripheral blood over the number normal in the individual, and this increase, never a diminution, in the polymorphonuclear varieties, but generally a marked absolute and relative gain over the number previously present."

You will see that by this definition we distinguish leucocytosis from leukæmia. In leukæmia, of which I shall speak later, we get as many as 500,000 white blood cells per c.m., but although there is a vast total increase the percentage of the polymorphonuclear is decreased and may be 26 per cent.

By the definition I have given you, we may have two kinds of leucocytosis:—

1. That in which the relative proportion of the various white corpuscles is unchanged.
2. That in which the increase simply and solely depends on a gain in the p.m.n. variety.

The former we may term the physiological increase and the latter the pathological.

The theories as to how a leucocytosis is produced are numerous. Not one meets with general assent and the exponents of the many different views fill columns in the Lancet and nobody seems any the wiser. Did we but know the actual cause of a leucocytosis our position in blood examination would be very different, but the many discussions on the subject, the fact that each authority has a different view, bring clearly home to us all that for all practical purposes any satisfactory conception of so important a question is at present absolutely hopeless.

Physiological leucocytosis may be present in several conditions:—

1. In the new born.
2. In digestion.
3. In pregnancy.
4. After parturition.
5. Moribund state.
6. Violent exercise.
7. Massage.
8. Cold baths.

The last three we may put aside as apparent leucocytosis being merely due to changes in the peripheral blood at the expense of the systemic. In the *new born* there may be 17,000 rising to 36,000 after a meal, and up to two years of age, 30,000 is not a very high count. In *pregnancy* it occurs in most primaparæ, in the latter months and at onset of labour may be 16,000—18,000. After *parturition*.—This might be confounded with that due to a septic condition if one is suspected, but then a differential count would get over the difficulty. After *food* has been taken there is an increase often up to 9,000; no food for some time, no leucocytosis. In the *moribund condition* the longer it continues the greater is the leucocytosis and in cases of pernicious anæmia it may become so great as to simulate leukæmia. In a patient in this condition the blood count rose from 7,800 to 59,300 before death.

To return to our second class, namely, pathological leucocytosis, we find it occurs under several conditions, such as—

(*a.*) Post-hæmorrhagic leucocytosis.
(*b.*) Leucocytosis in malignant disease.
(*c.*) Leucocytosis in toxic conditions.
(*d.*) Leucocytosis due to therapeutic or experimental influence.
(*e.*) Inflammatory leucocytosis.

In *post-hæmorrhagic* cases a considerable increase has been noticed even in an hour, and the count may show 16,000–18,000. In many *toxic* conditions there is a leucocytosis of more or less degree. Such conditions are:—

Gas poisoning, rickets, cirrhosis, uric acid diathesis.
After tuberculin injections and thyroid extract.
After salicylates and cinchonism.
After intravenous salt solution injections.
During and after the administration of ether.
Acute delirium.

The leucocytosis of *malignant disease* has been regarded when present to be due to inflammatory changes taking place round the neoplasm, or else to the production of secondary deposits in other organs.

It depends upon the following conditions :—
Position of tumour.
Cancer of œsophagus, leucocytosis due to starvation.
Cancer of kidney usually large leucocytes. And also
Cancer of sternum and sometimes stomach.
Its size, growth, and number of its metastases, the more rapid the growth the greater the leucocytosis.
The resisting power of the individual, whatever that may be.

Again, we may have a leucocytosis due to therapeutic influence. It has been shown that gentian, oil of anise, oil of peppermint and camphor, all produce an increase in the number of leucocytes (not, mind you, a physiological increase, but a pathological one), while ethyl alcohol, quinine and caffeine produce no effect.

Lastly, we turn to by far the most important division of this class—inflammatory leucocytosis. Here it is that we find such excellent material to aid our diagnosis.

Now, an inflammatory process may be either serous, purulent, or gangrenous, the two latter as a rule giving a higher count than the former. But, and this is important, we must be careful in inferring that the amount of leucocytosis is a criterion of the nature of the morbid process. The leucocytosis is a resultant of two forces — the resisting power of the individual, and the severity of the disease. Since the resisting power of the individual must, and always will be, an unknown quantity, we are only courting disaster when we endeavour to diagnose on the blood examination the condition of the inflammatory process. As an example of this temerity, I came across in one of the journals a short account of a case in which a patient with appendicitis was blood-counted, and, owing to the leucocytosis not exceeding 12,000 to 14,000, operative interference was not deemed necessary. Next day the patient became suddenly worse; operation was performed, and it was found that a large abscess had burst into general peritoneal cavity. Had an operation been performed earlier, there is no doubt that the patient's life would have been saved.

With a mild infection and good resistance we get a small leucocytosis.
With a less mild infection and less good resistance we get a moderate leucocytosis.
With a severe infection and moderate resistance we get a moderate leucocytosis.
With a severe infection and poor resistance we get no leucocytosis.
With a severe infection and good resistance we get a marked leucocytosis.

It is obvious from the foregoing table that we can get a moderate leucocytosis under two conditions, namely, with a moderate infection and a fair resistance, and with a severe infection and a moderate resistance. From this one might almost say that it is nothing short of criminal to diagnose the inflammatory condition from the leucocytosis, because the resistance of the individual is an unknown quantity. Failure to call in operative interference until too late may, as in the case which I have just quoted you, incur the sacrifice of the patient's life, and therefore the practice must without a shadow of a doubt be most certainly condemned. We sometimes meet cases where there is no leucocytosis, but a differential count shows that there is a considerable increase in polymorphonuclear cells. This indicates that the same cause, whatever it be, is at work as in processes which produce an absolute increase. Amount of exudation is not in itself a measure of the amount of leucocytosis, for in erysipelas and scarlet fever there may be a leucocytosis as high as that of pneumonia or empyema. Again, fever in itself has no connection with leucocytosis, since many febrile affections run a normal course with a normal number of leucocytes. Acute spreading inflammations seem to produce a greater increase in white corpuscles than do chronic conditions, and nearly all leucocytoses are preceded by a period of leucopenia.

I have put down a list of the most important infections or inflammatory conditions in which leucocytosis appears :—

I. Infectious diseases with comparatively slight local inflammatory processes :—
1. Asiatic cholera.
2. Relapsing fever.
3. Typhus.
4. Scarlet.
5. Syphilis (secondary stage).
6. Erysipelas.
7. Bubonic plague.

II. Infectious diseases with more extensive local lesion :—
1. Pneumonia.
2. Variola.
3. Malignant endocarditis.
4. Actinomycosis.
5. Trichinosis.
6. Glanders.
7. Beri-beri and multiple ascites.
8. Acute rheumatism.
9. Gonorrhœa.

III. Local inflammatory lesions :—
1. Abscesses wherever situated.
2. Carbuncle and Furunculosis.
3. Appendicitis.
4. Osteomyelitis.
5. Inflammation of serous membrane.
6. Gangrenous inflammation.
7. Various skin lesions, such as herpes, pemphigus, psoriasis.

We have dealt with diseases producing a leucocytosis and there remain for us to consider conditions in which there is no leucocytosis present, and several other morbid states which are equally important.

Leucocytosis is conspicuous by its absence in—

1. Enteric.
2. Malaria.
3. Influenza (most cases).
4. Rubella.
5. Tuberculosis, including—
   - Incipient phthisis.
   - Miliary tuberculosis.
   - Meningitis.
   - Peritonitis.
   - Ostitis and periostitis.
   - Pleuritis.
   - Pericarditis.

In some of these affections, notably in later weeks of typhoid and miliary tubercle, the leucocytes are diminished.

We must now consider leucopenia, which must be regarded as a decrease in the number of white cells in the peripheral circulation, as compared with the number normal for the individual.

We find such a condition :—

1. In the conditions of starvation and malnutrition caused by cancer of the œsophagus, anorexia nervosa.

In one case where a patient had starved himself for six months from motives of economy the leucocytes were only 2,500.

Such leucopenia is often associated with lymphocytosis, of which I shall speak later.

2. Short hot baths or prolonged cold baths temporarily produce the same result.

3. In miliary tuberculosis and the later weeks of typhoid, as I have mentioned before. This condition is also associated with lymphocytosis.

4. When a case of leukæmia is complicated with an infective process such as pneumonia, the number of leucocytes and myelocytes may fall below normal. For instance, in a case mentioned by Cabot, the blood count fell from 40,000 to 419 in three weeks, but the differential count was unchanged—lymphocytes 98 per cent.

I have spoken several times of lymphocytosis which may be regarded as a relative increase in the lymphocytes, or young cells in the blood, *with* or *without* an increase of the total leucocyte count.

If we have an increase of total leucocytes and a lymphocytosis, we cannot distinguish the blood from that of lymphatic leukæmia, but must be guided by the course and other symptoms of the disease. We may get a lymphocytosis in the blood of healthy infants as much as 60 per cent., and in many diseases of early childhood. There seems to be a tendency on the part of the blood to return to its infantile type, so that any condition which arrests or retards the development of the child, such as, say a summer enteritis, may produce 60 per cent. of young leucocytes, (lymphocytes) a condition normal for an infant of three weeks, but very high for a child of three years. Rickets and congenital syphilis produce similar results.

In adults there are several states which are associated with relative lymphocytosis, such as chlorosis, pernicious anæmia, anæmia of secondary syphilis, and in the later weeks of typhoid fever. It may be present in Grave's disease and a few other conditions.

In mentioning the above instances I have referred, for the most part, to relative lymphocytosis. Outside lymphatic leukæmia, absolute lymphocytosis is extremely rare.

With regard to the value of a lymphocytosis as a means of diagnosis, it may be borne in mind that absolute lymphocytosis, coupled with glandular enlargements, is the one reliable method of detecting lymphatic leukæmia. The diagnosis of obscure syphilitic conditions is aided by the coincidence of lymphocytosis and eosinophilia, of which I shall now treat.

Of late years a great deal of work has been done with reference to the eosinophile cells of the blood, and the work done on this subject seems to point to it being of some practical use in the near future. We might define eosinophilia, as an increase in the percentage of eosinophiles in the circulating blood with or without an increase in the total leucocyte count. The normal percentage varies between ·5 per cent. and 4 per cent.

Eosinophilia has been noticed :—

1. In affections of bones (sarcoma, leukæmia, osteomalacia).
2. In many affections of skin (pemphigus pellagra).
3. In ovarian disease, and disease of female organs of generation.
4. In disturbances of sympathetic nervous system.

There seems to be at first sight little connection between these various classes, but other facts suggest that they are not altogether unconnected.

For instance, we find eosinophilia in bone disease and genital trouble, and they do not seem to have much in common, but in osteomalacia we are aware that it is most apt to occur in pregnancy, and, in some cases, has been cured by ovariotomy. Similarly with regard to the generative organs and the sympathetic nervous system, all sorts of vasomotor troubles and psychoses are associated with menstruation, climacteric, and ovarian and uterine disease. Lastly, the connection of skin with both the sympathetic nervous system and trouble involving the genital organs of the female is seen in the trophic disorders and dermatoses of hysteria and ovarian disease. With regard to the diagnostic and prognostic value of the eosinophilia, the following has been suggested by Neusser :—

1. Between a tumour connected with the genital system and one not so connected, eosinophilia points to former.

2. In determining whether a case of hysteria, neurosis, or psychosis is liable to be benefited by ovariotomy, the presence of eosinophilia favours the operation.

3. In malignant disease, of or involving the osseous system, the presence of an eosinophilia might be of service.

4. In doubtful cases of syphilis, eosinophilia combined with lymphocytosis is in favour of specific trouble.

5. In distinguishing malignant liver disease from other liver trouble eosinophilia points to the latter.

6. In pernicious anæmia increased eosinophiles indicate an active regeneration of blood and a better prognosis.

In giving you these lists I merely offer them as lines along which research might well be undertaken by competent examiners, and I am well aware that for diagnostic purposes they are of very little use. Still a day may come when with increased knowledge we may find them of the utmost value.

I should now like to say a few words about leukæmia and then conclude this rather exhaustive examination.

The distinction between leukæmia and leucocytosis I have sufficiently dwelt upon.

Speaking shortly, leukæmia is of two kinds :—

1. Spleno-medullary.
2. Lymphatic.

In spleno-medullary leukæmia the blood is most characteristic. Besides the presence of nucleated reds we may get as many as 500,000 white blood corpuscles per cubic millimetre. This introduces a new cell called the myelocyte, which is present to the extent of 40 per cent. and even 50 per cent. The presence of myelocytes is not typical of a leukæmia, for they have been observed in pernicious anæmia and several other diseases and conditions, such as Hodgkin, Addison, Rickets, starvation, but never in any proportion like that of leukæmia.

The absolute number of polymorphonuclear cells is greatly increased but relatively diminished, being only in many instances 30 per cent. It is, however, in the lymphocytes that the greater relative diminution occurs to make room for the myelocytes. They are reduced from 20 per cent. or 30 per cent. to an average of 7 per cent., although their absolute number is always increased.

In lymphatic leukæmia the white count generally does not exceed 150,000 per cubic millimetre, and the lymphocytes make up 90 per cent. of the total.

By the blood examination we may distinguish leukæmia from the following :—

1. Hodgkin's disease, both splenic and glandular.
2. Tumours of spleen and vicinity.
3. Enlargements of lymphatic glands from tubercle, syphilis or malignant disease.
4. Hydronephrosis.
5. Huge leucocytosis from any cause.
6. Chronic malaria.
7. Amyloid disease.

Leukæmia from Hodgkin's disease.—But for the blood count the pathology of the two diseases is identical. In Hodgkin's there may be a moderate leucocytosis of p.m.n. variety and a moderate anæmia. The difference between leukæmic blood and such a condition is obvious.

Tumours of spleen, and more especially of kidney, are apt to be mistaken for leukæmia. Cabot mentions three cases of "leukæmia" in one year, whose blood he had been asked to examine, and all of them turned out to be malignant disease of kidney. In all of them there was a very large tumour in the left hypochondrium, together with a large increase of white cells. In two of them the blood was freshly examined, and the great number of white cells seemed to confirm the diagnosis of leukæmia. Differential count of the stained specimens showed only marked leucocytosis with 90 per cent. p.m.n. and no myelocytes.

Hydronephrosis.—Occasionally the sac is so large and tense that in one case it presented as a hard solid tumour. Here a count showed the blood to be normal, and so leukæmia was excluded, and also malignant disease in all probability.

Huge leucocyte count as in pneumonia or malignant disease may often pass the 100,000. Differential count showing 90 per cent. increase of the adult cells or p.m. nuclear instantly clears up the diagnosis.

We have considered rather fully the variation of the blood corpuscles in health and disease and it remains for me to point out the great use of the hæmatocytometer.

Take chlorosis for example. The red blood count coupled with the hæmoglobin estimation is the sole means of certain diagnosis. The same may be said of pernicious and secondary anæmia, for without the hæmatocytometer we could not diagnose them. Its decision is final. In the leukæmias the hæmatocytometer aids us in giving the number of white corpuscles present. Their number in spleno-medullary leukæmia often reaches 500,000 per c.m. while in the lymphatic variety 150,000 is about the average. The diagnosis rests, however, not on the hæmatocytometer but on the differential count. Nevertheless we can get a good idea of the progress of the disease by watching the increase or decrease of the white corpuscles. Again, in the diagnosis of a morbid condition associated with an enlarged spleen we can differentiate conditions such as splenic anæmia, Hodgkin's disease, cirrhosis of the liver, either alcoholic, syphilitic, or hypertrophic, and old cases of malaria from the leukæmias by the blood examination.

In what we term "blood" diseases we see, as I pointed out to you earlier in this paper, that in their differentiation the hæmatocytometer is invaluable. Each disease produces a characteristic change in the blood, which is simulated by *no other* disease, and thus our diagnosis is absolute.

Very different, however, is it when the hæmatocytometer is applied to distinguishing diseases other than those under consideration. Of late years attempts have been made to diagnose by this instrument the presence of an inflammatory lesion, such as a deep-seated abscess, and in some cases this method has met with success. But in a moderate leucocytosis, say of 15,000 per c. m., as I have already shown to you, there are so many pathological states with such an increase in the white corpuscles that we are hopelessly at sea. Here it is that

our method fails us. We know *nothing* about the actual cause of the leucocytosis. We do not know why some people should have a small leucocytosis and others a large leucocytosis under apparently the same pathological conditions. We try to explain it by talking about the "resistance" of the individual. That is only another means of cloaking our ignorance, because we do not know what such an expression means. For instance, a patient comes into the ward and has his blood examined in the ordinary course of events, and they find a leucocytosis, say of 12,000. Now, what does that mean? Nobody knows. Not a soul has any idea, and no one is any the wiser for it. It is a confession of our utter ignorance of the pathology of the blood, nothing more and nothing less. But, you will say, supposing he has a leucocytosis of 25,000 and an increase in the polynuclear variety, we know that he (probably) has some inflammatory process going on, even to the formation of pus. Then we can look about for this inflammatory focus, and if an abscess has formed, open and drain it. Very well, here is a case in point. On page 236 of the Guy's Hospital Gazette for 1903, date June 6th, is an account of a patient admitted into Stephen Ward. He gave a history of sudden pain in the epigastrium ten days before admission, for which he sought relief in an infirmary. His temperature was 101° on admission, and he complained of epigastric pain, the abdomen being slightly rigid. The blood was examined, and contained 12,500 leucocytes per c. m. After admission he had numerous rigors, sweated profusely, his temperature went up and also his leucocytes, which were 31,250. I think it was chiefly on the influence of the latter that a laparotomy was done and the abdomen thoroughly explored. Nothing abnormal could be detected, no perforating gastric or duodenal ulcer, no appendicitis, nor any peritonitis. No fluid was found in the pleuritic cavities. Patient was returned to bed, and next day was fairly comfortable, with a leucocytosis of 9,375. Gradually the symptoms returned. The patient had numerous rigors, his temperature went up to 105°, he sweated profusely and the leucocytes were 32,184. For a fortnight he continued in this state, and then seemed to improve. Finally he grew dissatisfied and left the hospital. Soon after his departure, he developed a well-marked secondary syphilitic rash and throat, and it is probable that this disease was the cause of all his trouble.

This case exhibits in an excellent manner the utter futility of attempting to place any reliance on the leucocyte count. He had no pus anywhere in his body, and yet his condition and the blood count clearly indicated, on the hypothesis of a large leucocytosis, that some considerable inflammatory condition was present. The leucocytosis in this case was the chief point in persuading the operator to perform a laparotomy.

The hypothesis that a large leucocytosis must necessarily mean a considerable inflammatory state is not tenable. The same thing occurs in appendical abscesses when physicians attempt to diagnose the inflammatory condition from the leucocytosis. They say that as long as the leucocytosis keeps below, say 25,000, they will not consent to operation. Gentlemen, I think it must be pretty obvious to all that this is only courting disaster. What right have they got to make such a dogmatic statement? They are assuming that a low leucocytosis means a less inflammatory state than that accompanying a high leucocytosis—an argument which has absolutely not a leg to stand upon. I have given you an instance where a patient's life was sacrificed by such arguments as these.

Before concluding this paper I think I ought to quote you a few cases which illustrate the use of blood counting in diagnosis. In giving you these cases I have adopted a plan which, I am sorry to say, is seldom followed by advocates for and against the subject in question. I think it only fair in quoting cases to you in which the hæmotocytometer has rendered valuable aid in arriving at a diagnosis, that I should also show you the other side of the picture, and mention to you cases where the instrument has utterly and miserably failed. I shall endeavour to obtain typical cases.

Case 1.—Man 30 years of age, anæmic, enlarged abdomen and dyspnœic. Spleno-medullary leukæmia suspected. Blood count, reds 3,000,000, whites 300,000. Hæmoglobin 42 per cent. Obviously leukæmia. Differential count 40 per cent. myelocytes. Diagnosis of spleno-medullary leukæmia confirmed.

Case 2.—Girl aged 23, with enormous spleen, moderately anæmic. Diagnosis without blood examination doubtful. Blood count 3,000,000 reds, 7,000 whites. Diagnosis, splenic anæmia. Autopsy, cirrhosis of liver.

Case 3.—A boy aged 15. No previous illness until week before. Had noticed lumps in groins and axillæ since. Diagnosis, probably acute tuberculosis or Hodgkin. Blood, 3,800,000 reds, 43,750 whites. 95 per cent. lymphocytes. Diagnosis, lymphatic leukæmia.

Case 4.—Woman, 56, admitted for painful swelling in left side of ribs. Difficult to say whether splenic or renal. Examination of blood revealed 3,000,000 reds, 9,500 whites. 70 per cent. polynuclear. Autopsy, pyonephrosis. Blood count useless.

Case 5.—Girl of 18, admitted for abdominal pain, headache, and moderate fever. General appearance suggested typhoid Blood examination revealed leucocytes 40,000, polymorphonuclear 88 per cent. Diagnosis, probably pus in abdominal cavity. Confirmed by operation, which revealed pyosalpinx.

Case 6.—This case is one I have already quoted you. Man admitted for rigors, sweats, and abdominal pain. Leucocytosis 31,000 with increase of polymorphonuclear. Diagnosis, pus in abdomen. Laparotomy performed. Nothing abnormal. Later patient discharged and developed secondary syphilitic manifestations.

Case 7.—Patient admitted for pain in right iliac fossa and malaise. Tumour to be felt. Diagnosis, appendicitis. Blood examination, leucocytosis 14,000 with polymorphonuclear 90 per cent. No operation performed in consequence. Recovery of patient.

Case 8.—Patient admitted for pain in right iliac fossa and diagnosis of appendicitis made. Leucocytosis 14,000,

increase in polymorphonuclears. No operation performed in consequence. Result, death of patient two days later from peritonitis.

Case 9.—Patient admitted for pain in right iliac fossa and diagnosis of appendicitis. Leucocytes 8,000 with increase in polymorphonuclear. Tumour felt in right iliac fossa. Operation performed in spite of low blood-count, and foul abscess containing two pints of green, stinking pus opened and drained.

I have now arrived at the last stage of this paper and I shall endeavour to make it as short as possible.

Briefly I will cite the use of blood counting as :—

1. In diagnosing absolutely the various blood diseases, such as :—

Primary anæmia.
Pernicious anæmia.
Spleno-medullary leukæmia.
Lymphatic leukæmia.
Splenic anæmia.
Hodgkin.

2. In giving a prognosis on the above diseases.

3. Given a leucocytosis, we can differentiate the blood disease from others both by the actual count and by the differential method, thus—

Pneumonia from leukæmia.
Carcinoma from pernicious anæmia.
Cirrhosis of liver from splenic anæmia.
Inflammatory conditions from conditions non-inflammatory.

4. Given a leucopenia in an obscure febrile disease, the diagnosis rests between typhoid and tuberculosis.

5. An increase in the polymorphonuclear cells suggests, but by no means is proof of, the presence of an inflammatory condition.

We may sum up the abuses of blood counting as follows :—

1. In accepting the results of unskilled examiners, however keen, as correct.

2. In examining the blood of patients in whom the diagnosis is perfectly obvious.

3. In attempting to diagnose diseases other than blood diseases by the blood examination.

4. In deciding absolutely whether operative interference would be deemed necessary or not.

With regard to the last statement, I should like to conclude this paper with the words of Da Costa :—

"The surgeon who attempts to use the blood count in appendicitis as a pathognomonic sign will soon fall foul of disasters, but he who regards it only as a symptom, invariably to be correlated with other equally if not more important clinical manifestations, cannot fail to find this method of inquiry of signal value in routine clinical surgery."

A Pathological Meeting of the Society was held on November 21st, in the Wills Library, under the presidency of Mr. H. F. Bell Walker. There were thirty-three members present.

The following specimens were shown :—

1. Aortic regurgitation with pulmonary embolism, infarction of the kidney, and nutmeg liver.

Mr. M. G. Louisson.

The following table from Cabot puts clearly the distinctive differences between the foregoing diseases :—

	Red Cells.	White Cells.	Young Leucocytes.	Adult Leucocytes.	Myelocytes.	Normoblasts.
Leukæmia (s.m.)	About 3,000,000.	450,000.	7·6 per cent.	50 per cent.	37 per cent.	Very numerous.
Leukæmia (lymp)	About 3,000,000.	100,000.	96 per cent.	3 per cent.	Absent.	Rare.
Hodgkin	About normal.	7,500.	Normal.	Normal.	Absent.	Absent.
Tumour of, or near spleen... ...	Usually dimished.	20,000 to 40,000.	Greatly decreased.	Greatly increased.	Few.	Few.
Leucocytosis in general	—	May be over 100,000.	Greatly decreased.	Greatly increased.	Few, if any.	Few at times.
Chronic malaria	Much diminished.	Somewhat increased.	Usually increased.	Usually decreased.	Few, if any.	Few.
Amyloid disease	Usually diminished.	Somewhat increased.	Usually decreased.	Usually increased.	Absent.	Few.
Hydronephrosis	Normal.	Normal.	Normal or decreased.	Normal.	Absent.	Absent.

2. Sarcoma of the humerus.
Mr. G. H. N. MacAlister.
3. Epitheliomatous ulcer of the cervix uteri.
Mr. P. P. Cole.
4. Fœtus with cystic kidneys and liver.
Mr. Blake Odgers.
5. Granular kidneys and hypertrophied heart from a child of twelve. Mr. P. A. Peall.
6. Carcinomatous appendix cæci. Mr. Stevenson.
7. Spherical growth at the junction of the larynx and œsophagus. Mr. W. M. Mollison.
8. Liver containing abscesses following Malta fever.
Mr. R. Felton.

The micrococcus deleterisis had been found in the pus by Dr. Eyre, and Mr. Felton believed that this was the first case of its kind.

9. Carcinomatous ulcer of the duodenum blocking the bile duct and pancreatic duct.
Mr. F. G. Goble.
10. Stenosis of the pylorus following ulceration.
Mr. Bell Walker.

Mr. Wallace showed the following microscopical preparations :—

1. Pneumococci from peritoneal pus.
2. Anthrax bacilli from wound three days after infection.
3. Tetanus bacilli from scalp wound a fortnight after infection.

The above were discussed by the exhibitors, and by Messrs. Russell, Ticehurst, Cameron, Bowen, May, Webber and Hughes.

The Society adjourned at twenty minutes to ten for coffee.

The next meeting of the Society will be held on December 5th, in the Smoking Room, at 8 o'clock.

Mr. K. Black will read a paper on "The Relation of Dental Caries to Disease." Mr. F. W. Morton-Palmer in the chair.

From the Gazette's Special Pathologist.

NOTICES.

G. M., Hertford.—This periosteal growth is a spindle-celled sarcoma, with large areas of hyaline degeneration in it. A section of the secondary growth in the lung shows that the sarcoma has undergone much mucoid softening with the formation of small cavities.

H.G.A., Nottingham.—A vertical section through the nipple and subjacent indurated portion of this breast exhibits much fibrous tissue surrounding the nipple ducts. There are no indications of malignant disease, but this fibrous tissue seems to be actively growing, which will explain the enlargement of the breast. There is no inflammation or catarrh of the ducts.

W. L. W. M., Huddersfield.—This growth from the alveolar margin of the jaw is a typical squamous-celled epithelioma, containing many cell-nests.

PATHOLOGIST.

The Evergreen Freshman.

"Prithee, greet this man with acclaim, Sirs,
He's a very good fellow of Ours."

The average reader of "The adventures of Mr. Verdant Green" is apt to close the book with the remark, "Very well written, but obviously overdrawn." That is because the average man has never made the acquaintance of the noble fresher.

This session, a man who had just come up, acquired an idea, which no amount of remonstrance could induce him to discard. It was as follows:—

"The sartorius is the longest muscle in the body. It arises from the ligamentum nuchæ, passes through the foramen magnum,—where it forms the medulla oblongata—courses through the posterior mediastinum, takes three turns round the small intestine, and is inserted into the hip, where its fascia forms Poupart's ligament."

Now, many people would declare this impossible; but it is a simple statement of fact. I myself tried gently but firmly to remove this false impression; but my account of the sartorius (from ant. sup. iliac spine, to int. surface of tibia) was politely disbelieved. He said, he had got his information from an assistant demonstrator, and everybody knows that they cannot lie.

This man is a typical specimen of a freshman. He has "digs" at Honor Oak Park, and he still catches the 8.30 train every morning, in order to be in plenty of time for an anatomy lecture, which touches on subjects he does not understand, and will not even be required to start until next year. Next winter, when the lectures *might* help him a little, he will catch the 8.52, and be the unhappy victim of a "lock-out," three times out of four.

"All freshmen must possess a half-set of bones" (vide Regulations); this is, of course, in addition to the complete set, which the majority of people lay claim to. This "half-set of bones" is a source of great trouble and vexation of spirit, to the freshman. He is advised to avoid "the clean white bones," because they are improperly marked. He is also told never to get bones which have been coloured, as they may mislead him. If he is the proud and happy possessor of dirty bones, he is warned that they are dangerous, because nobody knows where they come from, and they may be the remnant of a corpse with some loathsome disease.

Having settled this ossified difficulty, our freshman becomes a nuisance. He reeks of bones; he carries them with him everywhere, he talks, thinks, and argues, bones; and at last, justifies himself by "passing" Bones.

All freshmen, or nearly all, start their career with a new "Gray." It is a well known fact, that as their knowledge of anatomy increases, their care of the book decreases. For the first three months it is covered with brown paper. For the next three it has its own cover intact. After that, it becomes daily shabbier and dirtier,

its leaves become loose and drop out, and, at the end of the year it is an offensive, dilapidated wreck.

When first he comes to the hospital, he carries a bran new bag, full of his text-books. This phase, however, is too good to last. The bag goes first and the books disappear one by one. At the close of the second summer session, a pocket Gray and a Schäfer are usually the sole survivors.

No freshman ever thinks he looks fresh. He tries to make up for all his deficiencies by an abnormal amount of swagger. The first time he takes friends round the hospital is a treat for "the immortal gods," consequently more than a treat for the mortal man. The friends innocently ask him a lot of questions. When he does not know the correct answer—which happens four times out of five—he makes up for it by an ingenious system of lies which would excite the envy of Munchausen and put Jules Verne to shame. He is quite in the right about this. Were he to plead ignorance about anything, from the number of cubic inches of stone in Guy's statue to the amount of salary paid to the ward maids, he would be considered an ignoramus, and an intelligent public would think, "*He* won't do much good in his profession."

It is but a short time since we read a magnificent tribute to "The man wot runs the 'Orsepital." Now, *every* freshman "runs" the hospital. He is sent up to "walk it" but he always imagines that he "runs it." He thinks how pleased his people will be when he pulls off the "Arthur Durham" and the "Michael Harris." He is glad of the "Wooldridge Memorial Prize," as that will give him a chance to show his ability in another subject. He congratulates himself upon the fact that the Treasurer gives gold medals for both medicine and surgery, as it looks better to secure a pair.

If anyone takes offence at these remarks, we are sorry. Everybody knows that freshmen—especially Guy's freshmen—are good fellows, so that remark is superfluous. Also, be it remembered, all this applies equally to myself, for time was when I was "fresh," I wish that I had not grown "stale." A. S.

Oxford and Cambridge Dinner.

An old custom, which had been in abeyance for several years, was revived on Wednesday, November 25th, when about forty of the Oxford and Cambridge men at Guy's Hospital dined together at the Bridge House Hotel. The chair was taken by Dr. Brailey. The purpose of the dinner was professedly to bring into closer contact with each other, the Oxford and Cambridge men now at the hospital, and even if a goodly number of those present were already well acquainted, there were enough new men present to thoroughly justify the occasion. The evening was most successful in every way, and its success was largely due to Dr. Pitt and Dr. French, for in addition to the immensity of trouble which they had taken with the necessary preliminaries, they spared no effort to make everyone at peace with their neighbours.

After the loyal toast, the chairman proposed "The Universities of Oxford and Cambridge and Guy's Hospital," and the connecting links honoured the toast enthusiastically. Then the tables were cleared, and the proceedings became more informal. That Mr. Ticehurst was in charge of the musical arrangements ensured their success. Songs by Mr. Goss, Dr. French, and Mr. Payne, were heartily applauded.

Then Mr. G. W. Nicholson proposed Dr. Pitt's health, and after this had been responded to, Dr. Pitt said that he was very glad to be present at this dinner. He hoped it would prove the first of a new series.

The last toast was that of the Chairman. This elicited an excellent reply, in which were something of home truth, something of irony, something of warning; and each one rejoiced to see his neighbour so kindly pilloried. Then followed a recitation by Mr. B. H. Palmer, and this, ambiguous as it may seem, brought a pleasant evening to a close.

Specialities.

MOSELEY'S FOOD.

Moseley's Food is one of the most recent manufactured "foods." It digests very rapidly and easily, and is to be recommended in certain cases of feeble digestion, owing to the fact that it contains no raw starch; this constituent being replaced by dextrins and the like. The following is roughly the percentage composition.

Proteids	21 per cent.
Carbohydrates	66 "
Fats	2 "
Salts	2 "
Water	8 "

Such an excellently compounded food ought to gain much favour among the medical profession and their patients.

JEYES' "CREOLIN (MEDICAL)" AND "CREOLIN (DISINFECTANT)."

The Jeyes' Sanitary Compounds Company have produced what appears to be one of the most efficient germicides on the market. This is "Creolin," a coal tar derivative, but not a homologue of phenol; and of this there are two preparations—"Creolin (Disinfectant)" which is eleven times as strong a germicide as pure Phenol, estimated by culture experiments with both staphylococcus aurens and tubercle bacillus, and eight times less caustic; and "Creolin (Medical)," an even more powerful germicide. This latter has an additional advantage in that it can be used as an intestinal antiseptic, and as such has been most successful; for this purpose Palatinoids are used containing three minims of the fluid; those destined for the intestine are coated with keratin to avoid gastric digestion. The company is to be congratulated in producing yet another compound from that rich field of research—coal-tar.

Reviews.

The price of books submitted for review should in every case be stated.

Diseases of Women. By A. L. Galabin, M.A., M.D., F.R.C.P. (J. & A. Churchill.)

We record with great pleasure the publication of the 6th Edition of Dr. Galabin's work on Diseases of Women. We have, for some time, been awaiting the issue of a good account of the Principles and Practice of present day Gynæcology - such an account as should be at once easy of assimilation for the student and reliable for reference by the general practitioner.

Of the many publications dealing with the science and art of gynæcology, there are two very largely used by students, everyone of whom knows the merits and demerits of each book. One is universally held to be of great value to the practitioner, but lacking the formation, cohesion and succinctness so necessary in a candidate's hand-book. The other has these good qualities, but is quite unreliable for reference, and is tedious in reading and perhaps a little despicable in spirit. None of these faults are to be found in the pages before us, but all the virtues. It is undoubtedly true that the best grouping for students' and practitioners' surgical works is geographical. It ensures facility of reference and readiness of comprehension. These qualities are unattainable in the symptomological and pathological methods of grouping.

Dr. Galabin opens with a very necessary chapter on the gross and minute anatomy of the female pelvic organs, follows with one on the means and methods of physical diagnosis, another on the rules for the management of gynæcological operations, and then goes on to describe the malformations, abnormalities and diseases of the female generative organs. In his descriptions he discusses thoroughly but briefly the causation, pathology, symptoms, diagnosis and treatment of the diseases in question.

Although one can assert that the great majority of Dr. Galabin's opinions on pathology are absolutely unassailable, yet we think that it is in his treatment that he excels, and especially in the operative section of treatment. His descriptions in that branch of the subject are clear, concise, and supremely intelligible. He is aided materially by numerous efficient drawings, diagrams and photographs, without which adequate explanation must be long and tedious. He has illustrated many new and useful instruments, few, however, as useful as Mr. Lane's flat forceps which he exhibits.

There are few faults to be found with this splendid production, and those usually connected with minor points. Dr. Galabin, we think, is much too niggardly in the matter of food for patients after these operations. Allowing only jellies and junket on the fourth day is conservative and irrational. We must also take exception to the inadequate description of antiseptic compressing, and we grieve to see the frivolous attitude he adopts towards the kidney with a damaged ureter. We would like to ask what possible purpose is served by sterilizing the head of the operator, and how Dr. Galabin would like to 'do silks' with indiarubber gloves on.

And where is the cystograph?

This, however, is mere cavilling. When we take down his last edition, containing 500 pages of closely printed, eye-aching matter, and observe its undignified size and form and old-fashioned illustrations, and then turn to this neatly-printed and tastefully bound volume of 700 pages, containing accounts of nearly all forms of treatment down to Finson light cure for tuberculosis, we are led to wish Dr. Galabin another twenty years of writing.

Sport.

Rugby Football.

STREATHAM v. GUY'S.

Guy's lost the toss and kicked off against the wind. A good run by McEvedy and a pass to Alcock and we pressed. The Streatham forwards broke away and took play into our half of the field, their half back with a couple of punts brought the play close to our lines, but Mullins from a line out again made ground, and a moment later Morgan put in a good run and transferred play again to the other end. From a scrum close to their line O'Brien, evading their half-back, got over and ran round behind the posts. Morgan kicked the goal. For some time play was even, the most noticeable play being a good dribble by Layton and Saunders. Then McEvedy made the best run of the day, running from near the half-way and arming off four or five opponents scored wide out; C. E. Jones made a good attempt to convert. The game was delayed by an accident to Morgan's clothing. Half time arrived with us leading by 8 points.

After the game was restarted, for some few minutes play was even. From a round of passing by Jones, McEvedy, and Morgan, the latter scored and also added the major points. Shortly after this Alcock scored under the posts and Morgan again converted. For a minute or two after restarting Streatham pressed, but Saunders and Layton brought back play to the half-way. Some passing by Cutler, O'Brien, and J. P. Jones, ended in the last named putting in a great sprint and scoring under the posts for Morgan to again convert. A little later Morgan landed a penalty goal. Towards the end Morgan dribbled over the line and scored a try, and again landed a fine goal. Guy's thus won by 5 goals, a penalty goal, and a try, 31 points to nil.

Remarks.—Cutler playing at "inside" half played well, and this is evidently his right place. All the other backs played well. The forwards got the ball quicker, and this is probably due to the scrum practice on Mondays and their better packing. They must also learn to wheel promptly.

GUY'S v. OLD MERCHANT TAYLORS.

This match was played at Richmond on November 21st. Saunders kicked off, and after some scrambling forward play our three-quarters got the ball from a scrum, and Morgan gained ground by a fine kick into touch. The Taylors' forwards dribbled into the Guy's half, where play was carried on for some time. Our opponents were gaining possession of the ball in the scrum nearly every time, and their three-quarters were only kept from scoring by the fine tackling of our backs. Good play in the loose by the Guy's forwards carried the ball back into our opponents' half, and Jones, gathering the ball in the loose, broke through in fine style; he passed to O'Brien, who made a beautiful opening, of which Morgan took full advantage and scored behind the posts. He converted his try. The Taylors, on resuming, pressed strongly and their three-quarters had plenty of opportunities, but their passing was very wild, so that our three-quarters had no difficulty in preventing them from scoring. Half-time was called with Guy's leading by five points to nil.

On resuming, our forwards at once got to work and took the ball well into our opponents' half. Louisson broke away from the scrum and initiated a passing movement which resulted in the ball being passed out to Alcock, who then made a magnificent run down the touch line, and after handing off several opponents scored a brilliant try in the corner. Harrison failed to convert. The Taylors kicked out, and good play in the loose by Mullins and Saunders took the ball back to our opponents' line. Our opponents now came away with a good forward rush and pressed for some time, but they could not score. Louisson and Ward being especially prominent for good defensive play. Archer, Mullins and Saunders, then broke away, and by good dribbling took the ball up the field and from a scrum Jones nearly broke through. Our forwards kept up the attack and Pinching nearly scored. Towards the end the Taylors' forwards pressed strongly, and one of their three-quarters, getting possession of the ball from a scrum, dropped a goal.

Shortly after this no side was called, leaving us winners by 1 goal 1 try (8 points), to 1 dropped goal (4 points).

Association Football.

GUY'S v. GUARDS' DEPOT.

Surrey Senior Cup.

The replayed tie in the above competition proved disastrous to our hopes. We lost the toss, and kicked off against a violent wind that, from beginning to end, knocked the bottom out of any combination amongst our forwards.

Playing with the wind behind them, our opponents pressed strongly, and in a scramble before goal the ball struch Jones on the arm and a penalty was awarded against us, from which a goal was scored.

Shortly after the re-start, one of those "regrettable incidents" which seem to mar all Cup Ties took place. The opposing left outside, after being fairly charged by one of our halves, deliberately kicked him, for which unsportsmanlike behaviour he was merely cautioned. From the free-kick, we took the ball down to within shooting distance, but our forwards were dispossessed, and the game travelled back to our end, and Collins was called upon more than once to save the situation. However, the Guards were not to be denied, and shortly after notched another point. For the remaining fifteen minutes of the first half we were hard pressed, but no further goals were scored.

After change of ends the situation was reversed. With the exception of three attempts which the Guards made to get near our goal, the play was confined to the lower end of the field. But try as we would, nothing could induce the ball to find the net. Certainly the wind was rather disconcerting, but one cannot help thinking that the shooting of our forward line leaves something to be desired. Three or four corners were forced in quick succession, but proved fruitless. And so on to the end, which found us beaten by two goals to nil.

Collins, in goal, and Pedrick, at right half, were in great form. Edey and Jones played a strong game at back, though the former might have been still more useful at forward. Some of his shots at goal in the second half led one to hope for a different ending to the game. But the luck of the British Army stuck to it, and so we lost.

Appointments.

CIVIL.

Anderson, Kenneth, L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer of the Banwell District by the Axbridge (Somerset), Board of Guardians.

Bent, Sidney C. H., M.D. Brux., M.R.C.S., L.R.C.P. Lond., has been appointed Senior House Surgeon to the Evelina Hospital for Sick Children.

Dukes, E. S., M.B. Lond., M.R.C.S, has been appointed Public Vaccinator for the District of Paparoa, New Zealand.

Harris, J., M.D., M.R.C.S., L.R.C.P. Lond., D.P.H., has been appointed temporary Assistant Physician to the Sydney Hospital, New South Wales.

NAVAL AND MILITARY.

Surgeon A. J. Wernet, R.N., has been appointed to the *Berwick*.

Captain C. M. Fleury, R.A.M.C., has been posted for duty to the Station Hospital, Bulford Camp, Salisbury Plain.

Staff-Surgeon J. D. Hughes, R.N., has been appointed to the *Pioneer*.

Births.

ALEXANDER.—On November 15th, at Sundon House, Walthamstow, the wife of Herbert Alexander, M.R.C.S. Eng., L.R.C.P. Lond., of a daughter.

HUDSON.—On November 19th, at Vine House, Cobham, Surrey, the wife of Arthur B. Hudson, M.R.C.S., L.R.C.P. Lond., of a son.

TYSON.—On November 18th, at Folkestone, the wife of W. J. Tyson, M.D., F.R.C.P., of a daughter.

Marriage.

GRIFFEN—MITCHELL.—On November 21st, at St. Mary's, Enfield, W. E. Griffen, L.D.S., son of Thomas G. Griffen, M.R.C.S., L.K.Q.C.P.I., to Clara Annie, daughter of William Mitchell, Esq., of "The Highlands," Enfield.

Death.

BAILEY.—On November 23rd, in Clinical Ward, Guy's Hospital, Alice Bailey, aged 24, from typhoid fever.

Ed.—R. E.

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Calendar of Coming Events.

December, 1903.

Sat. 19.—Messrs. Golding-Bird and Dunn's take-in; Drs., L. Doudney and R. P. Lewis; Cl., J. Goss.
1 p.m., Clinical lecture.
G.H.R.F.C., I., v. Richmond, away.
II., v. Old Merchant Taylors II., home.
G.H.A.F.C., I., v. South Eastern College, home.
II., v. Emeriti II., away.
G.H.P.P.S., Debate.

Tues. 22.—Lectures cease.
Christmas Exams. in Anatomy, 1st and 2nd Year's Students.

Wed. 23.—First half of Winter Session ends.

Thur. 24.—Mr. Jacobson and Sir Alfred Fripp's take-in; Drs., C. M. Stevenson and R. A. Chisolm; Cl., W. F. Box.

Fri. 25.—Christmas Day.
Out-Patients' Tea.
Concerts in the Wards.

Sat. 26.—Boxing Day. Medical School Office closed.

January, 1904.

Sat. 2.—G.H.R.F.C., I., v. Old Leysians, home.

Guy's Hospital Gazette.

DECEMBER 19, 1903.

Cerebral Tumour.

CLINICAL LECTURE BY DR. W. HALE WHITE.
October 17th, 1903.

GENTLEMEN,—We have in the hospital at the present moment, three cases of tumour of the brain, so I thought we might consider that subject to-day. We will take first the patient who came in first. She is at present in No. 3 bed in Mary ward; and our knowledge of the case begins by a letter from an old Guy's man, Dr. F. E. Wallis, who writes: "I have had a girl, æt. 18, in our cottage hospital for the last ten weeks. For many months she has had intermittent headache and pain at the back of her neck, followed by weakness in the legs and blindness, with double optic neuritis. No delirium, no disease of the lungs, no squint, no paralysis of any muscles. At one time she had persistent vomiting. For some time I regarded it as a case of tubercular meningitis, but now I am inclined to think it may be a cerebral tumour." We of course acceded to Dr. Wallis's request, and the patient was taken in. I think most of you have seen her. She is a girl æt. 18, and Mr. Hamilton, who made the report upon the case, found the following facts about her. She came in for persistent headache, associated with vomiting. The history was, that six months ago she began to have headache, intermittent in character, and chiefly in the occipital region. The symptoms became worse, and she found that her eyesight was becoming affected. She became very weak and felt giddy. For the last five weeks she has only been able to see a faint glimmer when the gas is alight. On admission, she was a healthy-looking young woman, with a good colour, but practically blind in both eyes, and very weak. She could not sit up in bed unsupported; sitting up at all causing intense pain in the head. The pain shot down the right side of the neck, causing the patient to moan and to clasp the back of her head. All those who saw her will agree with me that the headache was excessively severe. On examining her, Mr. Hamilton found that at the back of the head there was, on deep pressure, a point of tenderness on the right side below the external occipital protuberance. The pupils were dilated, and did not react to light or to accommodation, and the patient was blind. There was no nystagmus or squint, no paralysis of muscles. Ophthalmoscopically there was double optic neuritis very well marked indeed, in an acute stage, and more advanced on the right side than on the left. The vomiting, we observed after she had been in some time, had no relation

to meals. Nothing we could do in the way of drugs had the slightest effect upon her headache, and, for the reason I will give presently I asked Mr. Lane to see her. He took away a quantity of bone over the right lobe of the cerebellum, the object of that being to relieve the headache. That was done on the 18th September, the dura mater being opened. The brain looked healthy. On the 25th September there is a note to say that "the patient has no headache at all now." So you see the beneficial effect of the operation; even as early as the 25th; the note of that date further says the eyesight is improving slowly, and the outline of a person can be dimly made out. The headache has remained absent; I saw the girl yesterday; her headache has gone, and her sight has much improved, as the result of having the portion of bone taken away over the right lobe of the cerebellum.

The next case is in Miriam ward, in 22 bed, and Mr. Box has made the report. He tells us the patient is a woman, æt. 45, who came in for headache and pain in the back, with occasional loss of reason. Her friends said that on the 27th September she was seized with vomiting, having had a very bad headache for a week before. On that night she was awake all night, and talked a lot of nonsense. For some time before the onset of this illness she has had alternating attacks of depression and elevation of spirits. She came into the hospital, and we found she had well-marked double optic neuritis, but it was of an interesting variety, for there was so little swelling that the exudation did not much more than fill the cup, so that the disc was about flush with the rest of the retina; and, as it happened to be just the same tint, it required considerable skill to find the disc at all; but when found there was marked blurring at the edge and some exudation. She complained very much of pain in the head, she was sometimes sick, and she had a curious mental condition. Frequently she obviously did not know who we were round the bed, and talked in a strange manner. Dr. Craig was kind enough to see her, and he writes to me to say that "this afternoon when I called she was very drowsy, but when roused up she was clearly quite restless and confused, as she had been most of the afternoon, there was a certain amount of erotic tendency, and she told me that at times she was noisy and could not help it. Her memory was very uncertain. She is a most interesting case, and I should think that she has that form of mental abnormality, namely, an alternating condition of drowsiness and excitement, which has been set down to disease of the frontal lobe." That is very interesting, because before Dr. Craig saw her we concluded not only, as he does, from the character of her mental derangement, but also from the fact that she has now, since being in the hospital, developed ptosis on one side, that her trouble was in the front of the brain. Probably there is a large tumour in the right frontal lobe, which is large enough to jam the oculo-motor nerve against the base of the skull.

The third case is that of a woman in Miriam, in 21 bed, and Mr. Reinhold made the report of her case. He says that she was admitted for violent headache and sickness. And then he found that she had been under me this year; and many of the old clerks will remember her very well when Mary ward was where Addison is now. Then, as now, she came in because of violent headache and sickness. That was really all that was found the matter with her. The interest of the case then was that there was considerable irregular bony thickening of the skull. There was a divergence of opinion as to whether the case was one of cerebral tumour, or whether it was one of headache due to thickening of the bones of the skull and their growing in and so compressing the brain; as, for instance, you will remember that in the case of osteitis deformans with a thick skull you saw there were mental symptoms. The difficulty here was to know whether this girl was an instance like that, or whether she had cerebral tumour. The balance of evidence was in favour of cerebral tumour. On account of the intense headache, Mr. Dunn trephined and opened the dura mater, and that gave her great relief from her headache. We learned that since her discharge the patient was better for a few months, but during the last month the headache has increased steadily in severity, and is now worse than it has ever been. There is very frequent vomiting the patient often feels giddy; and, what is very

striking, and I want you to bear it in mind, is that she came back voluntarily and asked to be trephined again, because the previous trephining had relieved her headache so much. Mr. Dunn accordingly again trephined her, but I am sorry to say it has not relieved the headache. But the point here is, that the relief on the first occasion was so great that she asks for the same operation again. The bone which Mr. Dunn removed the other day was very thick. She has altered somewhat since her stay in hospital last January, for in the interval she has become sick at times, and also occasionally feels giddy. Also Mr. Dunn noticed, on the second occasion when he opened the skull, that the intracranial pressure was very great, and this is strong evidence that a cerebral tumour is present. Yesterday we found definite optic neuritis in her eyes for the first time since she had been under observation. So there can be very little doubt that she too is suffering from cerebral tumour.

Notice that all these three patients came complaining of intense headache. There are few things more necessary for you to remember in medicine than that whenever headache is at all constant it is your duty to carefully examine the eyes. If you do not do so you will make all sorts of mistakes. Headache is the most constant symptom there is of cerebral tumour, it is the most important, and it is very rarely absent in tumour. It is usually very severe, with exacerbations of severity; and this has been well brought out by these three cases. It is sometimes a dull pain, sometimes it is a tearing or stabbing pain, and it is increased by effort. Many of you saw that girl in 3 Mary; you can hardly imagine a more awful headache than she obviously suffered from, nor could you want a better instance of the severity of the headache being influenced by posture. Latterly she could not raise her head, on account of the pain which was brought on. You ought also to remember that the locality of the tumour has very little to do with the locality of the headache. There are, indeed, only two exceptions to that. One is, that if the tumour is superficial in the brain, and is therefore in direct contact with the skull, sometimes that part of the skull does feel the pain most, and there is local tenderness. The other exception is a tumour underneath the tentorium. As this stretches across the skull it shuts off the posterior fossa into almost a little cavity by itself, and so a tumour in that little cavity produces a local pain, owing to the increased pressure in the cavity caused by the presence of the tumour. And further, when the tumour is in that cavity, it would appear that the pressure is also transmitted a little way down through the foramen magnum, because it is common to get severe pain over the distribution of one or two upper cervical nerves, and that is shown very well in the case in 3 Mary. The pain, you will remember, was so bad in the neck that some raised the question whether she had not got disease of her atlas or axis.

With regard to the other symptom which was so marked in these three cases, namely, optic neuritis, that again is very very important. It is present in four-fifths of the cases of cerebral tumour. So that as the headache is the most constant symptom of cerebral tumour, and optic neuritis is the next, it follows that the combination of headache and optic neuritis is an extremely strong argument in favour of cerebral tumour. All the three cases which are in the hospital now show optic neuritis very well, the simplest and most marked is in the woman in Mary ward. There is a good deal of swelling in the disc, and it has that bluish-grey tint which is so characteristic of optic neuritis. As I said before, the neuritis in No. 22 Miriam is difficult to make out, because it is difficult to find the disc, and the swelling is not of the characteristic blue tint. The one in No. 21 bed is a very good case to look at. There is only a little exudation at the edge of the disc, but it distinctly blurs it, and it has that striate blurring which is so characteristic of optic neuritis. You will remember that it is much better to look by the direct than by the indirect method, because the blurring of the edge is especially marked observed in that way. There is a striated blurring, because the effusion is among the nerve fibres, and, as I told you a moment ago, the cup becomes filled up, and as the case goes on, the exudation is more grey-blue. It is necessary you should remember that the loss of sight bears no relation to the optic

neuritis. There may be severe optic neuritis and very little loss of sight; there may be great loss of sight and yet very little optic neuritis. And another important point for you to remember in this connection is, that the position of the tumour has no relation whatever to the optic neuritis. Tumours in any part may cause it. Look at the case in Mary. The woman has cerebellar tumour, she has intense double optic neuritis, but so has the case in Miriam with a frontal tumour. And the optic neuritis of cerebral disease, you ought to remember, is very nearly always bilateral. I cannot tell you why it occurs, but it is important that although increased intracranial pressure is certainly not the sole cause of the optic neuritis, it is undoubtedly a contributory cause in some cases, because you will remember, the woman who is now in No. 3 bed in Mary ward was trephined, and since then the optic neuritis has receded and she has partially regained her sight; yet the only thing, as far as we can see, that the trephining has done is to relieve her intracranial pressure. But that the pressure is not the sole cause of the optic neuritis is undoubted, for many a time there is severe optic neuritis and very little increased intracranial pressure. On the other hand, there are cases of cerebral tumour in which the increased intracranial pressure is very great but there is no optic neuritis. So with regard to the causation of it, you can sum up our knowledge by saying that there is more than one cause, but we only know one, and that a contributory cause, namely, marked increase of intracranial pressure. Another important point is, that nearly always you will find that any case of severe optic neuritis which you meet with means there is serious mischief, usually intracranial mischief. You never must look lightly on optic neuritis as a symptom. But first of all I will tell you of a case, showing, that occasionally it apparently does not indicate serious intracranial disease and clears up. Many years ago, a lad æt. about 16 was sent to me, and he had double optic neuritis. A well-known ophthalmic surgeon also saw him with me, and said he must have an intracranial tumour. He had no other symptoms of intracranial disease. Out of charity to his mother —as he was her only son—we decided not to tell her what we thought. The optic neuritis slowly cleared up, and afterwards the boy became a well-known athlete; and he is now in robust health, with perfect sight. His optic neuritis was associated with trouble in his ear, which had spread up from a sore throat. And you will find also that Sir William Gowers mentions cases of optic neuritis which are associated with ear trouble. What the association is I have no idea. But I mention that interesting case only to point out to you, that I think it is almost the only one I have ever come across in which double optic neuritis did not mean severe disease. So you cannot exaggerate the importance of double optic neuritis. I can tell you the history of cases in the contrary direction as showing its importance. A few years ago a patient who was admitted was said to be suffering from hysteria. She had various nervous symptoms, and, as a matter of routine, as we do in every nervous case, we had a look at her eyes, and found double optic neuritis; so we diagnosed cerebral tumour. It happened that that very evening she dropped back in bed and died. A cerebral tumour was found in the post-mortem room next day. So if we had omitted to look at her eyes, we should have missed the correct diagnosis.

One other case to show the immense importance of this has turned up most opportunely. Only yesterday afternoon I saw a woman who had seen many oculists, here and on the Continent, and everybody agreed she had double optic neuritis. It was observed as long ago as 1900, and it can easily be seen now. She had no other sign pointing to any intracranial disease; so that although some of the oculists she had seen had said she had intracranial tumour, others said they did not think she had. But yesterday, when I saw her, the double optic neuritis had begun to go on to the stage of atrophy; she was sick, and she had already begun to complain of severe headache. There cannot be any doubt now that for all these years that woman has had a very slow-growing intracranial tumour; and the oculist with whom I saw her said he concurred, that that was the correct view. My point, that the optic neuritis may be the only

sign of cerebral tumour, is well illustrated in this case. This optic neuritis lasted three years, so there was formerly a great temptation to disregard it, because until recently other signs of tumour had not appeared. The headache and optic neuritis, you will observe, do not in any way show you where the tumour is, and they are much the most important symptoms of the whole group, which indicate that a tumour is present but does not show its position.

But there are also many other symptoms which occur in cases of cerebral tumour but which do not indicate where the tumour is. The next most important is vomiting. It bears no relation to food; there is no anorexia, the tongue is clean; it is slightly more likely that the patient will be sick if the tumour is below the tentorium. You will notice that our cases illustrate this symptom; they have all been sick. The next is a slow pulse. That often occurs in a cerebral tumour, and has no localising value. One of our cases had a slow pulse. Another symptom which occurs, but also often does not indicate where the tumour is, is giddiness. Giddiness is especially likely to occur if the tumour is in the cerebellum. No. 3 Mary will remind you of that fact. Then also, quite apart from any localising value, convulsions may occur. The woman in No. 22 bed in Miriam ward is stated to have been convulsed before she came in. These convulsions, which are independent of the position of the tumour, are quite separate from the convulsions which are known as Jacksonian epilepsy, and indicate that the tumour is in the so-called motor area. Another symptom irrespective of the position of the tumour is mental perversion. It is not quite true to say that mental symptoms are irrespective of the position of the tumour, for they are more likely to occur if the tumour is in the frontal lobe or in the lateral lobe of the cerebellum. But still, usually they are not of very much localising value. Again, people with cerebral tumour are very liable to waste as the case goes on. The woman I saw yesterday complained that she was now losing flesh. Often a case of cerebral tumour may, like a case of meningitis, have retraction of the abdomen and be constipated. All these three last symptoms are independent of the position of the tumour. Also towards the end of the case there may be a rise of temperature and Cheyne-Stokes breathing. All those symptoms which I have now given you, amounting to about twelve in number, are nearly always independent of the position of the tumour. There are two symptoms which also occur irrespective of the position of the tumour, but which may be described as merely mechanical. The first is thinning of the cranial bones. We have in our museum some most beautiful specimens of the thinning of cranial bones, which occurs with cerebral tumour. It is irrespective of the tumour touching the bones, and it appears that the general increased intracranial pressure leads to absorption of the bone. You will see in the museum a skull with bones very little thicker in parts than quite thick writing paper, so that you can see the light through them, and that was due to absorption in a case of intra-cranial pressure associated with cerebral tumour. And lastly, in children in whom the sutures are not firmly united, the head may be enlarged as the result of the presence of the tumour.

Supposing you have decided, as we have in all these three cases, from some of these symptoms, that there is a tumour, quite independently of any indication where or what the tumour is, the next thing you have to do is to try and find where the tumour is. To do that, you require an accurate knowledge of anatomy and physiology—anatomy, for instance, of the positions of the nerves at the base of the brain, so that you may know where a tumour is, from its pressure on this or that nerve; physiology, to know precisely which part of the brain has to do with word-blindness; precisely where the motor-area is, and so forth. We must, however, confine our attention to cases like those before us to-day.

In the first place, it is most exceptional to find a cerebral tumour at the post-mortem room, and for it never to have been suspected during life. I only know of that occurring once, and it was when I was demonstrator of anatomy. We accidentally came across a cerebral tumour in a man in the dissecting-room whose body had been sent from the hospital to the dissecting-room. And on asking those under whom

he was while in the hospital, they said they had not noticed any symptoms of cerebral tumour. But Dr. Fagge expressly mentions in his book that with all his experience he had never come across a case of cerebral tumour found accidentally in the post-mortem room.

The striking thing about our cases is the fewness of the symptoms. It is true those present are conclusive evidence that a tumour exists in each case, but there are hardly any indicating where it is. One part of the brain where a tumour may be and give very few symptoms indicating where it is, is the pre-frontal region. But in such a case there may be mental symptoms, as we know there are in the patient No. 22 in Miriam ward. Another part of the brain where a tumour may exist with very few localising symptoms is the parieto-occipital region, although there may be visual symptoms, usually either hemiopia or word-blindness. And if the tumour is on the right side, there it is less likely that there will be any symptoms indicating the position of the tumour, for you will remember it is the left side of the brain which has to do with word-blindness. Again, the lower part of the temporo-sphenoidal lobe is an area which does not give much indication of a tumour being present when it occurs there. Again, the lateral lobe of the cerebellum may sometimes have a tumour in it and yet give no clue to its position. So I should have said that the most likely places to find a tumour when it has not during life given any indication where it is, although you know from the optic neuritis, the vomiting, and so forth, that there must be a tumour, are the pre-frontal region, the parieto-occipital region—especially the posterior part,—the lower temporo-sphenoidal convolutions, and perhaps the lateral lobe of the cerebellum. When you think how large is the area, disease of which often gives no localising symptoms, the wonder always is that cerebral tumour so frequently gives these symptoms, but you must remember they may be absent sometimes even when the tumour implicates the motor area. It appears to me that the want of localising symptoms from a tumour is dependent upon several things. In the first place, the amount of brain destroyed is important. A tumour will often push brain away rather than destroy it. Further, sometimes an apparently small tumour gives rise to symptoms, apparently localising but not really indicating its position, because it greatly increases the intracranial pressure, and the increased pressure is felt upon other parts. Another reason why the localising symptomatology is so variable, is because it must depend upon how the tumour interferes with the blood-supply; and it must also depend upon the rate of growth of the tumour, and the degree of irritation produced by it. I think you will find that tumours most often and most surely indicate their position, when they press upon cranial nerves. Next, those in the motor area most frequently give correct localising symptoms, but remember that sometimes localising symptoms may appear very definite, and yet after death the tumour is not found where we expected to find it. Before leaving this subject, there is another point which it is very necessary to remember about patients—especially women—with cerebral tumour, namely, that it often appears that the controlling power of the brain is in some way lowered; the patient's control over herself when she has tumour is not the same as if she had not. And that is not surprising. Think what a disturbance a cerebral tumour must cause, even apart from the mere lowering of nervous self-control by the intensity of the pain. So it comes about that you are constantly having to deal with a number of hysterical symptoms superadded to those of organic disease. There is no rule to be given; your skill in clinical medicine will be shown by whether you can dissociate the hysterical from the organic symptoms in a case of cerebral tumour. That they may be numerous there is no doubt. Here are notes of a case which illustrates this point; even at this distance you can see these diagrams. Notice how the anæsthetic areas (undoubtedly in this case due to hysteria) vary from time to time. The patient had definite hysterical symptoms superadded to those of the tumour which we knew from her optic neuritis and other symptoms. I show you a photograph of the tumour which was found post-mortem.

In one of the cases we have to deal with to-day the tumour is probably cerebellar, in the other probably frontal. With regard to whether you can localise a cerebellar tumour, it is important to remember that when the tumour is in the cerebellum the headache is most likely to be over the posterior fossa of the skull, and to extend a little way down the neck. And vomiting, I have told you, is more likely to occur when the tumour is in the cerebellum; also people with cerebellar tumours are particularly giddy. Much interest has been shown of late in the question of the position of the head in a case of cerebellar tumour. Unfortunately the case in 3 Mary does not show it; or at any rate she is so ill that we cannot properly examine her for it. But I thought, that as the point has only recently been studied, it would interest you if I showed you a photograph of the position of the head which some of these cases of cerebellar tumour take up. The subject of the photograph had a tumour in the right lateral lobe of her cerebellum, and you will see that her ear is down on the side away from the tumour, but the face is turned up towards the right. Why that should be we do not know. But, clinically, what you have to look out for is, that if the tumour is on the right side, the left ear will be down towards the left shoulder, and the face will be turned up as towards the tumour, and *vice versâ* if the tumour is on the left side. Not by any means every case of tumour of one of the lateral lobes has this symptom. And, further, it has been observed in hydrocephalus. Another point, which you may remember I was able to demonstrate in the wards not long ago, is, that sometimes when a tumour exists in the lateral lobe of the cerebellum, there is weakness of the arm and leg on the same side.

With regard to frontal tumours, that is a very wide subject. Let us examine some of the symptoms which it might be expected would be produced by frontal tumours. First, one school of physiologists have stated—I quote from Bianchi—that "the frontal lobes are the seat of co-ordination and fusion of the incoming and outgoing products of the several sensory and motor areas of the cortex." Professor Schäfer, on the other hand, in his text-book says: "I have in several cases completely removed in the monkey the whole of the inexcitable area of both frontal lobes without producing the slightest sign of mental or intellectual dulness." So experimentalists do not help us much. Nor do the clinical cases help us more, because, while some people believe that well marked symptoms may be present with frontal tumour, other people believe that no symptom can be detected at all. Dr. Bolton, who has been the last writer to examine these questions, is of opinion that the frontal lobes have a great deal to do with mental processes. He bases his opinion upon three points, which we cannot stop to go into: 1st, their development; 2nd, their histology, and 3rd, the morbid histology of the insane. He says: "The writer hence considers it proved that the great anterior centre of association, lying in the pre-frontal region, is underdeveloped on the one hand in all grades of primary mental deficiency, and on the other undergoes primary atrophy with the development of dementia. It is therefore the region of the cerebrum which is concerned with the performance of the highest co-ordinating and associational processes of the mind." But when we come to clinical medicine we do, practically frequently, find tumours of the frontal lobe producing very few, if any, localising symptoms. However, we are fortunate, in the case in No. 22 Miriam, to see a tumour, probably frontal, producing well marked mental symptoms, which, as Dr. Craig says, are just the symptoms to be expected in tumour of the frontal lobe.

Here is a case illustrating the fewness of the symptoms which may occur in frontal tumours:—Alice H., æt. 26, was admitted into Guy's with severe pain and headache over the forehead and vertex. She had been ill a month, with pain over both eyes, shooting up to the top of the head. Sometimes she was giddy. None of her friends thought her ill; her brother thought she was a little mysterious before she died, and she often said she was thinking; but when asked what she was thinking about she declined to say. He did not think her memory, her reasoning powers, or her emotional faculties

were at all impaired. She was engaged to be married, and when taken into hospital at the request of her doctor was busy making arrangements for the wedding. So there was no evidence of any severe mental deterioration. She came in with double optic neuritis, had headache, and died shortly after admission. I found, on making horizontal sections, the left frontal lobe contained a large light-coloured greyish new formation, which, on the front outer part of it, contained a large cyst full of fluid. Except the part just mentioned, the whole body was healthy. Therefore, there was a case of a considerable frontal tumour which produced hardly any symptoms at all. And I mentioned to you the other day a case, which occurred at the Evelina, of a tumour of the frontal bone itself, which grew into and destroyed the brain, much of the tumour was burned away with caustic by Sir Henry Howse, who decided that that was the only way to deal with it; and a piece of brain came away with the tumour. The child got completely well, and she went to a Board school, and although part of her frontal lobe was destroyed she won several prizes at the school.

Having discussed the discovery and localisation of cerebral tumours, the next question is the nature of the tumour. I have not time to go into the matter fully, but by far the most common is tubercle, next glioma. So we will pass on, as these cases illustrate it, to the question of operation. You can operate for cerebral tumours with two objects. First, to remove the tumour. Probably hardly anyone here will ever be called upon to do that. With all the large number of cases which a big hospital brings before one, I have only twice seen cases where operation was done or desirable for the removal of a cerebral tumour. The reason is that so many tumours are either inaccessible, or too big to take out, or accompanied, as most tubercular ones are, by secondary deposits elsewhere. For some reason or another you will find, that only 8 per cent. of all the tumours of the brain that occur, are accessible to the surgeon, and that is, provided you are clinically skilful enough to tell in what part of the brain those 8 per cent. lie. Probably in many of them you would not have sufficiently accurately localised them to tell the surgeon where to operate. But that is not all. The experience of the last fifteen or twenty years has shown, that even when you take the tumour out, you often benefit the patient very little. You leave a scar and a great hole in the brain, it may be, the size of a walnut, and that often seems to so upset the whole cerebral mechanism that the patient is very little better off in the long run for having had his tumour taken away. So, as a matter of practice, the cases in which you find it desirable to cut out a tumour of the brain ought to be very few indeed. But there is another operation which we can do (and which we practised on two of our three cases) with great benefit. We can relieve the headache by relieving the intracranial pressure, and we know that in some cases the optic neuritis can be benefited at the same time. That is the reason why the case in No. 3 Mary was trephined. Her headache has been improved by this operation, and so has her sight. That is the reason why No. 22 Miriam has been trephined on two occasions. She has no loss of sight, but on the first occasion her headache was wonderfully improved by operation, which consists in taking away some bone and opening the dura mater.

Perhaps I can best illustrate this subject by giving you an account of what is a remarkable case, showing the benefit of this operation. It was that of a woman admitted into Guy's Hospital in 1893, with the history that her trouble had begun in 1892. The symptoms of her case were very severe headache, blindness, severe optic neuritis. Total blindness continued till August 31st, 1894. On that day she was trephined. She improved so rapidly that in three days the headache had gone, and in three weeks she could distinguish fingers held at a distance of five feet. Three months after the operation the sight again failed, and in less than four months the headache returned. Therefore, on January 15th, 1895, she having come back to the hospital of her own accord to ask for this operation, a considerable area of bone and dura mater was removed. The headache disappeared and the sight improved greatly. Two months afterwards the headache returned, and the sight again failed. Therefore,

on April 23rd, 1895, more bone and dura mater were removed at her urgent request. Again the headache at once disappeared and the eyesight returned. But now the improvement in both instances lasted only a fortnight. Therefore on May 22nd, 1895, again at her request, more bone and dura mater were taken away, the result being the headache disappeared and the eyesight improved. This time the improvement lasted longer, but eventually some headache returned and the improvement in sight was not permanent, and she became quite blind. She was, to her death, certain that the headache was less than before operation. She died in 1900, and I show you a photograph of the brain with the tumour in it. Bone was taken away four times for the relief of her headache and blindness, and with such benefit that on three occasions the patient asked that the operation might be repeated.

Another thing which should help you to decide as to operation is, that sometimes cerebral tumours are very slow growing and become quiescent. In such cases it is particularly desirable to relieve headache. Here is a case in point. Edith M., was admitted under my care on May 25th, 1898, with headache, complete blindness in one eye, and double optic neuritis. She was trephined and the dura mater opened. Her optic neuritis cleared up, the headache disappeared, the sight returned, and eighteen months after the operation Dr. Stamm visited her at her home, and reported that she had kept very well, had good sight, and only occasionally suffered from headache, and was able to do her work.

You will perhaps ask me what harm can follow this operation. The only objections I know are the following. There is the possibility of a hernia cerebri being troublesome. Only in one case, of the many I have had trephined, has there been serious hernia of the brain. Another difficulty is that the patient, for some reason I cannot explain, occasionally but very rarely, after trephining for relief of intracranial pressure, develops hemiplegia, but it is very exceptional, and has only occurred once out of the many I have had trephined, and the patient expressed himself as delighted that he had been trephined, because, after all, what is the powerlessness of an arm or a leg compared with the misery of a severe headache such as the woman in No. 3 Mary has?

I ought to add that sometimes, but not often, trephining and opening the dura mater fails to relieve the headache, and it goes without saying that damage to the discs may be so far advanced that the blindness is not better for the operation. Still if the headache is very severe it is usually worth a trial.

A Case of a Bullet lodged in the Heart Wall.

It would be unwise to lay too much stress upon the subsequent historic notes of the case of Max Meyer, a German, who is at once the most unfortunate and fortunate of men. Although he was shot in the heart two and a half years ago, he is at the present time in excellent health. The notes, for a translation of which I have to thank Mr. Sydney Jacobson, M.D., are unauthenticated; with which preliminary warning an abstract follows.

Max Meyer, æt. 22, on the evening of June 27th, 1901, received an 8 m.m. revolver bullet in his left chest, the weapon being but two metres distant. Shortly afterwards he was able to stand up and walk, but later, losing consciousness, he was conveyed to the clinique of Professor Frendelenburg at Leipsig. It is stated that he remained unconscious for three days.

On admission his pulse was 5 or 6 to the minute, rising to 18 per minute by the 2nd of July—three weeks after the injury. He was examined with the X-rays on admission, but without result. Hæmoptysis, cough and pains in the chest persisted for two weeks.

It is here mentioned that two weeks after the injury the pulse was 24 per minute, which statement is contradictory, on the face of it, to the preceding. Fever is recorded from the 29th of June to the 20th July. He was examined with the X-rays upon the latter date, and the bullet located. On November 2nd he was allowed to get up, and he gradually regained strength, his pulse varying from 10 to 40 per minute. On November 2nd, his pulse becoming intermittent, he was ordered to bed. Early in February his pulse was normal. He was examined by the X-rays daily from this date to September 1st, 1902, and was then discharged.

He fainted on November 3rd, 1902. He had noticed for several days previously that his pulse rate was falling, until on that day it was 13 to the minute.

Since then—*i.e.*, *for over a year*—he seems to have suffered no inconvenience, save when he runs fast, bends forwards or lifts heavy weights, when he experiences pain in the chest.

This concludes the summary of the notes, the most interesting features of which are the extraordinary pulse records, and the fact that at such an up-to-date clinique as that of Professor Frendelenburg, the bullet was undiscovered at the first X-rays examination—a margin must, however, be left for possible inaccuracies.

The patient is an exceptionally well-built young man, and but for the scar on his left breast he would attract no interest medically. The back and chest are bronzed—the back considerably, by the action, I believe, of the X-rays. Two light patches of uncoloured skin upon his back indicate where some protection to the rays was afforded, by some application, such as a plaister.

Upon examination with the screen the bullet may be seen showing through the spine, but slight lateral deviation of the rays shows the bullet clearly against the more transparent lung. The fact of the bullet moving synchronously with the left ventricle, the margin of which is so easily seen with the rays, suggests its presence

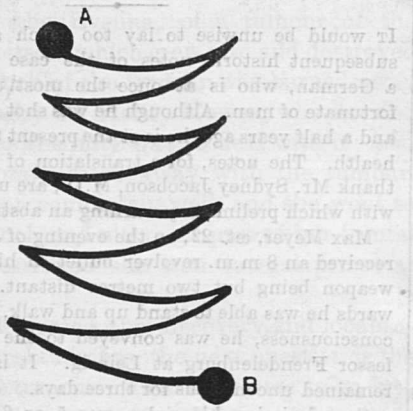


FIG. 1.

Diagram showing path covered by bullet.

A. Position at end of expiration.

B. Position at end of inspiration.

in the interior or wall of the ventricle. Its position being more to the right indicates the right ventricle, and the smallness of the bullet shadow when seen from behind means that it is nearer the back of the chest than the front. The absence of bruits and other heart symptoms, the regularly placed and unvarying excursions, suggest a bullet in muscle rather than free in the heart cavity. It therefore seems probable, from a consideration of these facts, that the bullet lies encysted in the posterior wall of the right ventricle.

The accompanying skiagrams are of mere passing value compared with the screen examination, for in the latter it is clearly seen what curious excursions the piece of lead makes, influenced by heart and respiratory movements. The first impression is as if some small live creature were being viewed hopping unceasingly from one spot to another. Careful observation shows the movement to consist of a jump from side to side, the path taken being represented by a line convex downwards.

The field of this horizontal movement moving vertically with the rise and fall of the diaphragm, I have endeavoured to indicate the bullet's path in the accompanying plan. Roughly speaking, the distance between the bullet's highest and lowest point is one-third of the breadth of the heart shadow. The extreme sideway variation is nearly half this. Perhaps the most instructive feature is the large vertical distance traversed by the bullet, confirming, as it unquestionably does, that the heart itself rises and falls considerably with the diaphragm excursions. It is incorrect to say that this case is unique, but since the advent of the X-rays nothing has been seen of such an unusual nature as a bullet lodged in the heart with but slight inconvenience to the recipient.

I have to thank Mr. Read and Dr. Chanorth Lyster for an opportunity of seeing this patient.

EDWARD W. H. SHENTON.

Obituary.

DEATH OF MR. ALFRED COHEN.

The loss by death of this well-known Governor is, indeed, a serious one for the Hospital.

His connection with the Institution began in 1886, when, in conjunction with Mr. Bristowe, he was instrumental in getting together a very large subscription—some £5,730—from the Stock Exchange, for the first Special Appeal fund for the Hospital. Shortly afterwards, on the nomination of the late Treasurer, Mr. Lushington, he was elected a Governor, and from that time evinced a most practical interest in all the affairs of Guy's. Many readers of the GAZETTE during recent years will remember him as a prominent member of the House Committee. Not only a munificent benefactor himself, he was able to influence, by his high position in the City, a large amount of support in aid of the Hospital.

His excellent judgment and kindly sympathy were always at the disposal of the powers that be, and one of his last acts in connection with this place was to send a most sympathetic letter and handsome donation towards the establishment of the department for "light treatment," the foundation of which is now being rapidly proceeded with.

A man who, while not wearing his heart on his sleeve, yet possessed a most affectionate disposition and many acts of quiet and unostentatious benevolence could be recorded of him.

His courage and endurance during his final illness from cancer were quite out of the common and won the admiration of all who saw him.

A most influential gathering at his funeral service in the Synagogue in Aldgate testified to the esteem in which he was held by his co-religionists and friends, when a high eulogium of his conduct and character was delivered by the Chief Rabbi.

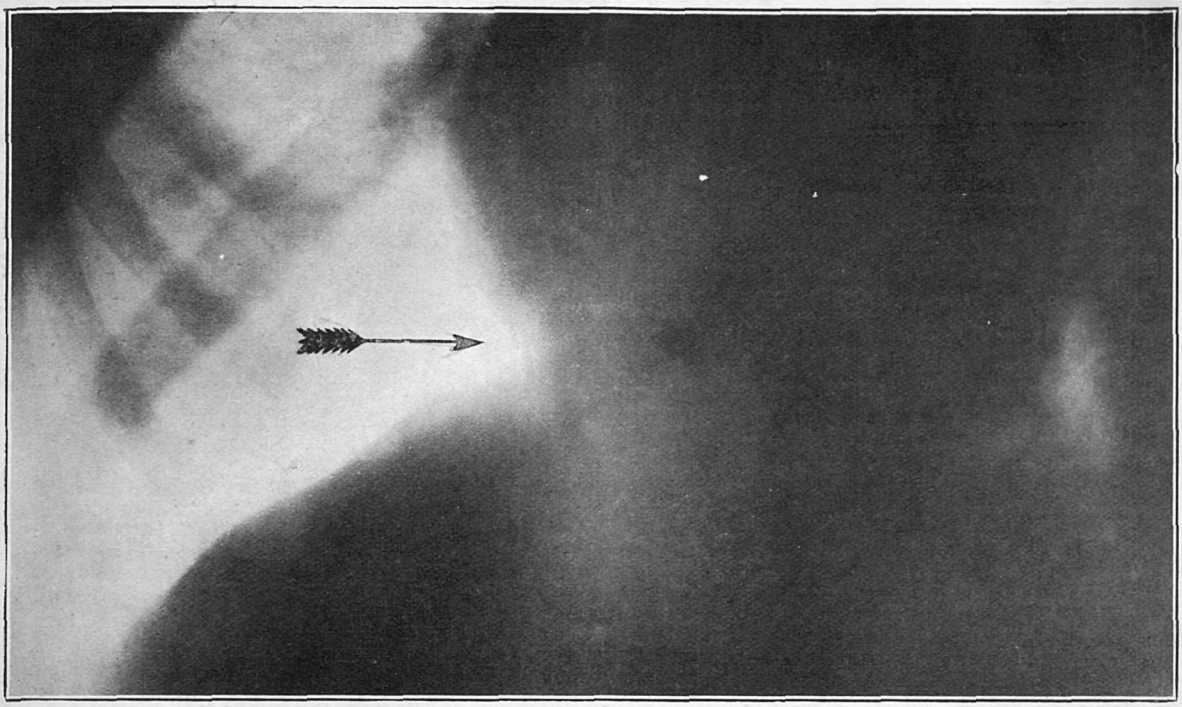


Fig. 2 (Front View).—Taken while patient held his breath. Exposure, 20 seconds.

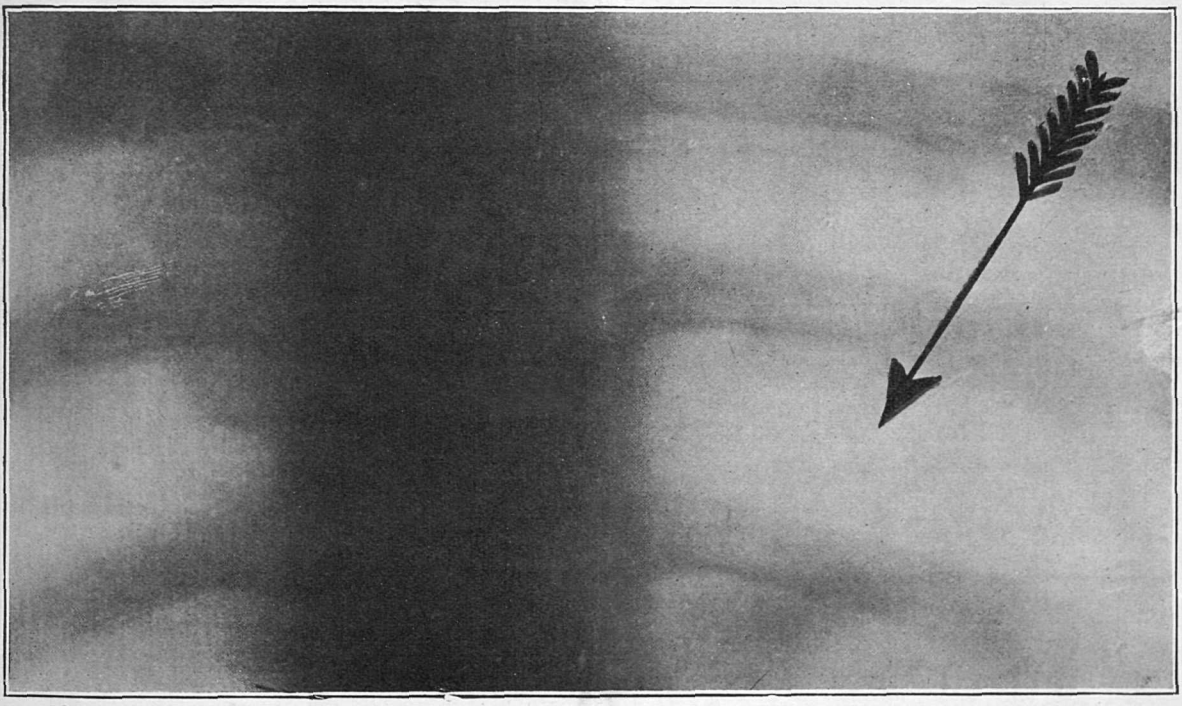


Fig. 3 (Back View).—Taken while patient held his breath. Exposure, 20 seconds.

Passim.

"I have always thought of Christmas time, when it has come round . . . as a good time—a kind, forgiving, charitable, pleasant time; the only time I know of, in the long calendar of the year, when men and women seem by one consent to open their shut-up hearts freely, and to think of people below them as if they really were fellow-passengers to the grave, and not another race of creatures bound on other journeys. And therefore . . . though it has never put a scrap of gold or silver in my pocket, I believe that it *has* done me good, and *will* do me good; and I say, God bless it."

Five more clear days remain to us, and after that the deluge. The general thaw in the social scale is already fast setting in, and even certain sisters are preparing to descend from that rarified atmosphere in which they ordinarily dwell, that they may meet and greet the astonished and somewhat embarrassed ward-clerk, who begins to find, like the pathetic cart-horse in the story book, that even he also is of use. In consequence of these proceedings decoration progresses as gaily as ever, and the wards begin to assume their annual verdant appearance. In the College also are wonderful goings-on, vocalists are being discovered wholesale by others and by themselves, while several gentlemen are in danger of forgetting their own identity, so many are the rôles they are called upon to assume.

The Christmas present of the Residents to the Sisters and Nurses is again to take the form of a theatrical performance in the Court Room. On such occasions as this it is most desirable that there should be as much variety as possible, and the veriest glutton after sensation (if it were possible that ladies could harbour such feelings) will be satisfied with the triple bill that has been decided upon. The first item will be an original duologue by a well-known Guy's man, whose identity shall on no account be disclosed until the eventful "first night." Suffice ft to say, that the dialogue is good, and the dénouement unexpected. With this bare skeleton let Rumour do her worst. "The Ghost of Jerry Bundler" was so successful last Christmas, and is so admirably suited for an amateur performance, that it has been decided to attempt a repetition of last year's success. The third item is an old-fashioned and rollicking farce in which the three female parts will be played by certain well-known gentlemen whose features most lend themselves to the portrayal of feminine expression. Mr. C. H. Robertson and Mr. Blake Odgers have undertaken the difficult rôles of business managers, whilst the fact that Mr. Woodward is taking an active part in all three performances goes very far towards ensuring their success.

It seems to be in the eternal fitness of things that Christmas should be the time par excellence for reminiscences. Perhaps the Old Year, mindful of its approaching pitiable end, would have us spare a thought for its many benefits, and lead us to the contemplation of the noble army of its forbears long dead-and-gone, amongst whose ranks it so soon will stand a mere matter of memory. It is certainly true that, at this time of the year, old friends and old times, old customs and old haunts form the staple evening topic of conversation in many a community, and perhaps there is a deeper significance than most people think in the emphasis laid by the superstitious upon the psychological importance of Christmas Eve. True to this universal instinct of Christmas reminiscence, we are reproducing in another column a quaint account of some aspects of Guy's Hospital more than half a century ago. The authorship is unknown, and though it is evidently the work of an old patient he could not have been quite one of the common run, for there is here an unholy knowledge of detail that would be quite beyond the ken of the average inmate. It would be adding a touch of pathos to suggest that memory has here been aided by a lively imagination, and perhaps there are some who can verify the statements of Mr. T. Browne, whoever he may have been. In any case, this hospital is a mine of memories, and we venture to present this as a not uninteresting sample.

The following is the calendar of events for Christmas day and the last four days of the year:—

Fri., Dec. 25th., 1 p.m.—Nigger Concerts, commencing in Ruth and ending about 7 p.m. in Astley-Cooper.

A NATURAL MISTAKE.

[*Popular Hospital Official* (*who is somewhat inclined to embonpoint*) *in answer to anxious enquiry.*]—"What me? No!! I AIN'T Father Christmas!!!"

Mon., Dec. 28th., 4 p.m.—Queen Concert.
4.30 p.m.—Ruth Concert.
5 p.m.—Lazarus Concert.
8 p.m.—Residents' Theatricals in Court Room.
Tues., Dec. 29th., 4 p.m.—Naaman Concert.
5 p.m.—Job Concert.
6 p.m.—Luke Concert.
8 p.m.—Residents' Theatricals in Court Room.
Wed., Dec. 30th., 4 p.m.—Martha Christmas Tree.
Thur., Dec. 31st., 7 p.m.—Astley-Cooper Concert.
Midnight, 1903–1904. — Solemnities around Guy's Statue.

After two years' tenure of the office of Surgical Registrar, Mr. Graham Simpson has left us to take on the duties of House-Surgeon at the Sheffield Infirmary, whither he carries the good wishes of all his friends at Guy's Hospital. Mr. Simpson's career, from his entry up to his appointment as Registrar, was a long series of successes, and those who have gone round with him in the Surgical wards can bear witness to the excellence of his teaching. It is, however, a great matter for thankfulness that so able a successor has been found, and we heartly con-

gratulate Mr. Ralph Thompson upon his appointment.

We should like to draw special attention to the article in another column on the Naval Medical Service. Coming from a man who was himself at one time a member of this branch of the profession, his observations carry considerable weight, and for those who meditate entering the Navy as medical officers it would be well to consider his words and be wise. To the unambitious man, well-pleased with single blessedness, whose spirit is content to bow constantly to a higher authority, and who is willing to ask for little and get less, to such doubtless, the life in this service may appeal as even exhilarating. But men of this stamp are happily rare in our profession, and so long as the Navy does not offer a chance of anything approaching a career, medical men will most wisely refrain from entering. It is extremely difficult to awaken the interest of the public at large in the welfare of so small a portion of the community, but interest must be awakened by some means, for it is unfortunately a matter of common observation that it requires nothing short of the cataclysmic to induce a government official to effect anything but a compromise.

Sir Alan Reeve Manby the distinguished Guy's man, whose recent knighthood we recorded in the Gazette of November 21st, has been further honoured by the Royal permission to accept and wear the Knight Commandership of the Danebrog, given him by the King of Denmark. He was a student here up to Christmas, 1870, somewhat later than we had thought, the explanation being that even in those days a post qualification year was valued highly. It is our pleasant duty, therefore, to still further congratulate Sir Alan, wishing him long life and greater honours in the future.

The Assault-at-Arms held in the Pavy Gymnasium on Friday, December 11th, was a most successful display from every point of view. To begin with, the room was crowded with men of all years, and the one figure that was necessary to complete the picture was that of Dr. Pavy, who was in the chair, taking a keen interest in all that went on. The boxing was not unnaturally the most popular spectacle, and the combatants in all cases justified the claim of this exercise to be called "the noble art," for hard knocks were taken in good humour, and the chances of defeat or victory were all part of the game. The fencing and single-stick bouts were conducted with considerable style and vigour, while the actual gymnastic display was a most praiseworthy item of the evening's programme. Mr. E. P. Minett, the energetic Secretary, is to be congratulated on the success of his efforts, and we hope he may be able to arrange for an Inter-Hospital contest to be held in the Pavy Gymnasium at an early date.

It may be as well to prepare our readers for certain small alterations in form and arrangement of contents, which will be instituted in the first Gazette of 1904. For the assurance of those enthusiastic souls who love the cover of their Hospital's journal, we hasten to explain that the changes will not extend to that, but that the lettering of the outside title will remain as old-fashioned as ever.

What should be an exceedingly interesting meeting of the Physical Society, takes place to-night in the College Smoking-room at 8 o'clock. Mr. Blake Odgers will occupy the chair. The evening is to be devoted to a discussion of Cancer, and judging from the systematic way the subject is to be attacked, this discussion should be exhaustive.

Reviews.

The price of books submitted for review should in every case be stated.

Kenwood's Public Health Laboratory Work. Third edition. Pages 606. (H. K. Lewis.) 10s. 6d. net.

There are few departments of medicine that attract a man less than State Medicine and Public Health, partly owing to their dry and uninteresting literature, but chiefly to the lack of human interest in the subject. This work does something to relieve the reproach levelled against most manuals, because it is readable, well printed, and on good paper, and the illustrations are clear and easy to follow. The fact that it has reached its third edition shows that it has found favour with students as well as with practitioners.

Barking Back.

"Nous avons changé tout cela."

We are indebted to Mr. Golding-Bird for the following manuscript, which was left for him some time back, in the Porter's lodge, by some person unknown. Two illustrations accompanied the letter, one a view (of sorts) of the Pathological Museum in the days of its infancy, the other purporting to be a diagram of the method once in vogue of hoisting a naked body on to a table. Whether it was employed in the Operating Theatre in the Post-Mortem Room, or in the Dissecting Room, the artist has not made sufficiently clear, consequently we have omitted the pictures! The manuscript has of necessity lost something of its originality in the process of reproduction.

Having met with an Accident Viz fractured Rib I came to Guys, the Surgeon who attended to me Mr Callaway, after Mr Cock who removed several Spicula of Bone which filled a match Box, now near seventy years back, and the sinus still open (I mention this for the number of years)
The out patients room (now the casuals) the Surgeon sat behind a screen, in the same room under the same the casuals where seen that had a stone floor, and about a dozen carboys, for the medicine mostly Lic. US or Iowtis Nigra or Sanza. ——
The Pharmaceo Department, now the offices in the front open from eight in the morning till five at Night ——
Dispensers Simpson & Mr Nairn, with black Aprons and white Flannel jackets, down some stairs, the Laboratory with Steam Engine and stones to grind the drugs, on the first of October, the counters, were filled with Drugs and Medicines for the staff to examine, and sign a Book
the dispensr had a fee of ten shillings that day, not open on Sundays, Lectures at seven in the Evening, I think for Surgeons only; ——
Beer and Libitum, brought in from the pubs, all who had cash, could have it, visitors morning & Afternoon every day, the same with Oysters or anything else —
Each ward illuminated, with a Rush light placed in a ~~cylinder, with perforated~~ Cylinder an extra Dip candle on ward table, if required for visits of Surgeon
I think that disinfectants, were out of Thought in that day for when the Ward required them, at the entrance, a Brazier or Devil so called, filled with Cascarilla Bark and Nitre, and Burnt the Ward filled with smoke, not quite so fragrant as Incense. Incense. ——

Biller Ward stood just on one side of Lunatic contained about eighteen Beds, a converted public House, one of the rooms six Beds only, I recollect six patients in the same, with Gangrene, all died in a Week. ——
Phillip - Samaritan, and Stebbon this side of Museum, a converted Hop. Store - Miriam Ward over Coach house on spot now - Kitchen &c. ——
six or eight small Houses close to, occupied by servants of the Hospital, also the Lying in Charity, the Lady Superior Mrs Larkin, who made and supplyed the candle, for the Ladies confined, about a quart each made, with Beer, Oatmeal, Sugar and Spice - All Hot
the next House a school for the Children, in the same row the Comparitive Museum Stables and Workshops about the spot now Anatomical, Mr Symes studio assisted by an Italian the name of Francis who done most of the work. ——
at the S. King St. gate, stood a watch Box, for the Guardian of the night, who called the Hour, always past 1 in a Clock Mr Donovan who fractured his Leg through the Box being turned over, and himself with it - Question who done it, not found out. ——
The Brewhouse stood on Spot now Chemical Laboratory, close to it the demonstrating Room joining the Mortuary, ~~the wound to fly through an opening in the floor above~~, next Hurst's the Artist's rooms, partly over two large Steam Boilers used for Brewing and Engine in Laboratory ——
On the days of the dinners. May and November, in the court room - at the bottom of the stairs, stood an old Lady, with white apron, and frilled Cap - and Table, with white cloth - Bread and Butter. Accetum and piperiti, with Barrels of Oysters, for any devotees Epicurius, the dinner all ~~cooked each~~ cooked in Hospital Kitchen ——

The Musical service of the Chapel, led by J. Hunt (Hunt) Barthman, with a Flute, left seat of the Tabernacle the Latter ——

The two new Houses outside, stand on the old Coach Yard and Stables, on the cabals of the window, carved, Sir A Cooper, Galen - Hunter & Hippocrates

I dare say that I have forgotten much about the Grand old place, and at the same time pardon the Liberty I have taken,

Yours sincerely Grateful
J Browne
Chirurgicus

A Case of Post-operative Hernia Treated by the Introduction of Prepared Silver Wire Filigree.

A Paper read before the Clinical Society of London, by Lawrie McGavin, F.R.C.S. Eng., on Nov. 27th, 1903.

Gentlemen,—The use of prepared silver wire filigree for the cure of post-operative, umbilical, and other herniæ, is of comparatively recent introduction; and although I am aware that many surgeons, among whom may be mentioned Schede, Witzel, Barker and others, have endeavoured to overcome the difficulty of the closure of large deficiencies of the abdominal wall, by the weaving in of silver wire at the time of operation, or by simple forcible apposition by sutures of the same material, I am as yet unaware of the performance of any operation in this country, in which the method suggested and practised by Willard Bartlett in America has been employed; a method which I think has much to recommend it, and which consists of the introduction into the tissues of a prepared network of silver wire filigree. Having recently had the opportunity of applying this method, I am tempted to bring the case before the notice of the Society, partly as one of clinical interest, but chiefly in the hope of hearing the experience of other surgeons on the subject with which this paper deals.

The history of the case in as follows: —

The patient, who first came under my care in July of this year, is a woman of 45 years of age, of spare build, healthy in every other respect than that for which she came to me, and having the prospect of many years of active life before her, but for her hernial condition.

About fifteen years ago, while in Australia, she underwent an operation for the removal of a fibroid tumour of the uterus; this was apparently incomplete, and Apostoli's method was then tried; subsequently a pelvic abscess developed, the wound broke down, and in a few weeks a ventral hernia commenced to form.

On inspection, I found the abdominal cicatrix much stretched and thinned out, primary union having obviously failed; and her condition one of great discomfort and considerable danger. On causing her to stand up, the whole of the suprapubic region bulged markedly forwards and assumed a roughly lobulated appearance, the actual dimensions of the swelling being five inches vertically from immediately above the pubes, and about four and a half in the transverse direction, the centre being rather to the left of the middle-line. The skin was not adherent to the mass, but beneath it were four or five hard lobulated tumours, some of them as large as a walnut, which presumably were composed of omentum. On coughing, the tumour bulged at a point two inches below and to the left of the umbilicus, and here bowel could be felt and partially reduced. The hernia was tender to pressure, and the patient complained of increasingly frequent attacks of painful dragging sensations when walking or standing. Frequency of micturition was rather troublesome and showed signs of becoming worse, and at times there were griping pains on defæcation, accompanied by nausea and sometimes by retching. No part of the tumour could be completely reduced, and it was clear that if such reduction were to be brought about by operation, a considerable amount of tissue would have to be sacrificed, and the prospect of permanent cure was therefore very slight.

Accordingly I determined to deal with the case by Bartlett's method, and following the directions of that author,* I manufactured a filigree of silver wire, using No. 27 gauge, and making about twenty loops on either side; when finished it measured five inches in length by two and a half in breadth. This was washed in ether and thoroughly sterilized.

At the operation I found the recti muscles separated by about four inches, the stretched and thinned out fascia between them being cribriform, and having five or six large masses of fibroid omentum projecting through its meshes, all of them being densely adherent; at the point of bulging above mentioned, a knuckle of bowel presented, and this could not be reduced.

The abdomen was opened just below the umbilicus, and by inserting two fingers I was able to free the omentum, of which I removed a considerable portion, and reduce the bowel; I then excised the whole of the intermuscular sheet of expanded and cribriform peritoneum and fascia, only retaining as much of the former as was normal in appearance.

The edges of the peritoneum could barely be made to meet owing to the tension, the suture repeatedly tearing out, and the same difficulty was met with in the muscular wall. I next stripped up the edges of the peritoneum from the overlying tissues sufficiently to allow of the introduction of the margins of the filigree on each side, and, placing it on the peritoneum, fixed it lightly in position with two very fine cat-gut sutures, passed round the central stem of the filigree and through the peritoneal junction. The muscles, which as above stated could barely be brought together, were then approximated by a form of removable deep suture with which I have been experimenting for some time, and which I have described elsewhere,† five stitches in all being introduced. The scar tissue in the skin was then removed and the wound was closed in the usual manner.

The deep sutures were removed at the end of a week, and the superficial at the end of ten days, the patient being kept in a firm abdominal binder. The subsequent history of the case is uneventful; she was upon the couch on the fourteenth, and left the hospital on the twenty-first day, having been perfectly comfortable, and having felt no inconvenience from the presence of the filigree. Her frequency of micturition had completely disappeared, and the bowels were acting without difficulty or discomfort.

* The Annals of Surgery, 1903.

† The Lancet, 1903.

It is, of course, much too early to claim this case as a cure, but seeing the excellent results obtained by American surgeons in this branch of operative surgery, it is, I think, reasonable to suppose, that given a primary union and an uncomplicated recovery, such an event may be looked upon as a practical certainty.

As the method has been so recently brought before the profession, it would be out of place for me to do more than report the case and show the subject of the operation; but I believe that it promises, if properly conducted, to place within our grasp many cases of hernia of all varieties, which have hitherto been considered to be outside the pale of practicable surgery. The chief points at which the operation aims are, the saving of time; the discounting of tension between the muscles when they *can* be brought together, and the presence of an unavoidable gap when they can *not*, by the insertion of a light metal mesh-work which is rapidly incorporated in the living tissues; and lastly, the complete and permanent cure of a condition which has too often been seen to recur after treatment by less perfect methods.

Should it be found impossible to get the edges of the peritoneum to come together, the difficulty could easily be met by the use of a large omental graft lightly sutured to the edges of the gap, than which it should be rather larger, so as to overlap to the extent of about a quarter of an inch all round; or if there should be danger of the graft dying, on account of its size, the omentum might be utilized to fill in the gap; but in this case the filigree should be rather more accurately sutured to the peritoneum.

In conclusion, I might point out that the above method has been very severely tested, and its efficiency demonstrated, by Bartlett, who reports the success of a case, in which the portion of the abdominal wall involved consisted ultimately of nothing more than peritoneum, filigree, and skin, the muscles refusing to come together. The case did well, and the patient remains sound two years after the operation. An operation which seems to promise relief to a host of sufferers from a condition, which, in the majority of cases, cripples their daily work, and in many renders their lives a burden to them, seems to me to call for a more extensive trial and wider publicity, at the hands of those surgeons who are in a position to submit such cases to this method.

Special Notice.

GUY'S HOSPITAL MEDICAL SCHOOL.
(University of London).

BACTERIOLOGY.

An advanced Course in Bacteriology, Practical and Systematic, adapted to the requirements of the M.D. (State Medicine) and the various Public Health Diplomas will be held from January to March, 1904.

For further particulars apply to the Dean.

The Naval Medical Service.

When I left the Navy in April last, I felt it was my duty to attempt to ventilate the defects and grievances of the medical department, in order to arouse the interest of the profession generally, and if possible of the public, in the matter.

My reason for so doing was, that there was a pretty general opinion that with a conservative body like the Admiralty reform must come from without.

Lord Selborne himself had publicly stated, that "suggestions for the solution of problems would be welcomed by both himself and his colleagues." I took it that the "problems" to be solved were the short-handedness and discontent among medical officers, so I ventured to send him some "suggestions;" the official "welcome" was a partly printed, partly written note, bearing the information that my letter had been handed to the Secretary of the Admiralty.

One of these suggestions was for more speedy promotion; this has been made possible within the last few days.

Other suggestions were as follows:—

"Much more control over our own affairs than we have now."

"Individual responsibility should be encouraged even among the most junior of us."

"Complete control and authority over the sick-berth staff—at all events in hospitals."

Also the appointment of an Advisory Board which should make a full enquiry into the organisation of the Service, in much the same way as was done by the Army Advisory Board in the first place.

I next attempted to interest the profession through the columns of the *British Medical Journal*, but what letters were printed, were relegated to small type, and latterly to no type at all. I fear me that the Editor does not consider the matter of much importance; that is a question of opinion. If I felt at liberty to show him some of the letters I have received from naval medical officers, he might change his mind; however, as they are private communications, I am afraid this change of mind will not be effected in this way.

I have gone on the assumption that the Director-General and their Lordships, being highly-paid public officials, have no right to object to their actions—which affect thousands of men—being criticised. I may be wrong, but I don't think so. Of one thing I am certain, I have not written a single word, whether right or wrong, except from a sense of public duty, and not in any way against an individual except in his public capacity.

I have also written to the *Morning Post* without success: for behold the path of the unrighteous—or unconventional—agitation-monger is a thorny one!

No help was to be got from Naval medical officers themselves, for no one on the active list dare write to the public press even anonymously, for fear of finding himself forthwith appointed to a "bug-trap" in the

back-of-beyond seas; unless verily he sells his soul to Mammon, and sings lustily of the joys of a life on the rolling main—happy, free and bold—and what dear, kind men their Lordships and all our seniors are. *That* of course is different and possibly leads to a flag-ship. It is different too, inasmuch as, although more pleasant to read, it does nothing to bring about the reform that is so badly needed. If these high-falutin gentlemen had been believed, we should never have got the quicker promotion which has just been tardily given us.

Although this is a great concession, the Navy can never offer a career to a really keen man until many other reforms have been effected. Specialism should be encouraged, the question of war promotion re-considered, the Director General should be on the Board of Admiralty, and not, as at present, under a post-captain many years his junior both in rank and in actual age, executive officers should no longer sit on Medical Boards of Survey, which are held for purely medical purposes. These among many other causes of discontent deserve investigation.

A little bird has told me that A Very Great Man Indeed (all capitals please Mr. Printer), sitting in a Very High Place, considers that I am "profoundly ignorant" in the matter. That may be, but if so I have only myself to blame, for having served in ships, and hospitals, both at home and abroad, and for a short time in marine barracks, I should have had singular opportunities of becoming conversant with my late service.

Finally, I think the thanks of all Naval medical officers are due to Dr. Bryant for the letters he wrote to the *British Medical Journal* on their behalf.

G. SICHEL.

Pass List.

University of Cambridge, December, 1903.

DEGREE OF BACHELOR OF MEDICINE.

H. A. Cutler.

DEGREE OF BACHELOR OF SURGERY.

A. R. Brailey.

University of London, October, 1903.

M.B. EXAMINATION.

EXAMINATION FOR HONOURS.

MEDICINE.

THIRD CLASS.—N. Ivens Spriggs, G. T. Wrench.

FORENSIC MEDICINE.

SECOND CLASS.—G. T. Wrench.

THIRD CLASS.—N. Ivens Spriggs, A. M. Webber.

In Lighter Vein.

GRAND ASSAULT-AT-ARMS.

SPLENDID STYLE OF THE STAFF.

[In emulation of the recent highly successful Students' Assault-at-Arms in the Pavy Gymnasium, the Staff gave a similar display in the Court Room, which it is to be hoped will become an annual function.]

The Editor of the GUY'S HOSPITAL GAZETTE kindly acted as judge. (I didn't.—ED.) Signior Andrioletti holding the watch, while Mr. Prestige held the Signior. Seconds were provided free of charge from the Junior Staff.

The proceedings opened with a spirited round between Dr. Savage and Dr. Craig, at the end of which, the former, remarking that there was no such thing as insanity, landed Dr. Craig a biff on the kissing box and put him to sleep for a tray of moons. The next item was a fine bout between Mr. Fagge and Mr. Hicks (feather-weights). Mr. Hicks, who has been training between Queen and the ground floor, was hardly up to form, and might yet train down a ton or two. Mr. Fagge's chances were lessened by an early blow on the smile in the course of the first round, but in rallying he punished his opponent, finishing up with a stinger on the equator. The first round of the foils between Mr. Higgens and Mr. Ormond ended somewhat abruptly, for the veteran, before you could say "knife," had both the Nag's lenses out, and had fitted him with blinkers. The second round between Dr. Fawcett and Dr. Eason, was a scientific exposition of the modern French art. Dr. Fawcett, whose foil was of centralization steel, was no match for the Gem of the Sentry Box, and was done over quickly five times. Dr. Beddard, in a single-stick contest with Dr. Pitt, remarked that it was absolute nonsense his opponent attempting to fight him, and that what he meant to say was this, viz., Dr. Pitt had hold of the wrong end of the stick. During the interval the Superintendent gave an exhibition of trick-riding on his motor cycle. This graceful performance was much admired. This was followed by a short turn by Professor Ffrench

who delighted his audience by his ventriloquial nape-o'-the-neck efforts, and by the assortment of wonderful animals he produced from his hat.

The second part of the programme opened with a novelty, in the form of a five-handed mill between Registrar Rudie, the Sheffield Slammer, and four Bantam Ward Clerks. The Judge awarded the prize to Rudie, but he, with his well-known courtesy, insisted on his little friends bearing off the palm.

Mr. Lucas, who recognised several of his old dressers in the crowd, did some remarkable heavy-weight lifting. When he had reached 250lbs. he exclaimed, "Something has got to go," and almost immediately his supinator snapped like a hungry tyke, and he was led away fainting by his House-Surgeon Gray—(it's Faulks really.—Ed.).

Proceedings terminated with a gymnastic display by the Physiological Phairies, Drs. Pembrey and Eyre. We regret to report that the latter, despite his cultivated aplomb, sustained a somewhat severe injury to the vibrio.

THE DAUNTLESS THREE.

Pupils' Physical Society.

A Meeting of the Society was held on December 5th, in the Smoking-room, Mr. F. W. Morton-Palmer being in the chair. There were thirty-three members present.

Mr. Kenneth Black read a paper on "The Relation of Dental Caries to Disease." The paper dealt comprehensively with the causation of dental caries, and its immediate and remote results. Considerable attention was paid to the relation between caries and difficult digestion, Mr. Black advancing the view that dental caries was usually the result, rather than the cause, of imperfect gastric digestion.

The Chairman congratulated Mr. Black on his paper, and spoke on several of the points raised, expressing his disagreement with the above-mentioned view as to caries and dyspepsia.

Mr. Angell referred to the importance of judicious extraction of irregular teeth in early life, and to the influence of heredity on the liability of the teeth to decay.

Mr. G. A. Ticehurst questioned the reader of the paper, as to the experimental evidence for his statement that the saliva became acid after a meal.

Mr. Webber asked about the liability to caries during an acute illness, and Mr. Holcombe Fuller also spoke.

After Mr. Black had replied, Mr. Ticehurst proposed that a vote of thanks be accorded him for his paper, and this was heartily carried.

The next meeting of the Society will be held on December 19th, in the Smoking-room, at 8 o'clock, and will be devoted to a discussion on "Cancer."

Mr. P. N. Blake Odgers will be in the chair and will open the discussion; the following members will also speak:—

Mr. H. L. Bowen on "Irritation as the Cause of Cancer."

Mr. A. R. Thompson on "The Bacteriology of Cancer."

Mr. A. R. Brailey on "The Causes of Secondary Deposits and Recurrence."

Mr. W. M. Mollison on "The Embryonic Theory of Cancer."

Mr. A. C. Cameron on "The Infectivity of Cancer."

Diary of Events.

(Composed in new Wills Library.)

Time.

10.15 a.m. —Have just settled down comfortably to read.

10.30 a.m.—Enter carpenter with bag. Commences to saw top off cupboard just behind me.

10.36 a.m.—Carpenter has left. Joy.

10.40 a.m.—Seven individuals commence beating carpets at back of Library.

10.50 a.m.—Lull in carpet beating. Carpenter now returns, and after planing the top of cupboard, seizes a large file and files top of a brass bolt for five minutes on end, producing such excruciating sounds that everyone in vicinity writhes in his seat.

11 a.m.—Carpet beating has ceased, and carpenter has left pro. tem. Animated conversation in the opposite division now commences by eight junior men over a bone.

11.10 a.m. —Carpet beating is renewed with vigour. Yells and shrieks coming from adjacent squash court.

11.20 a.m.—Return of carpenter with box of nails which he promptly spills over the floor under my chair.

11.25 a.m.—Carpenter is now hammering vigorously, with intervals of planing and filing. Carpet beating just recommenced. Carpenter hums an unrecognisable air.

11.30 a.m.—Carpenter is filing, carpets are being beaten outside, yells of exultation from squash court, animated conversation of junior students resumed, and prolonged expectoration from rather stout person wearing gold-rimmed glasses.

11.35 a.m.—Peall's billiard saloon. Miss in baulk.

G. R.

Appointments.

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants.—Messrs. M. Coplans, P. P. Cole, C. D. Pye-Smith, A. M. Webber, E. H. B. Milsom, H. F. Bell Walker.

Clinical Assistants in Medical Out-Patients.—Messrs. W. M. Mollison (Dr. Shaw); J. M. Barrionuevo (Dr. Beddard).

Dressers in the Throat Department.—Messrs. H. M. Goldstein, F. Barnes, J. H. Clatworthy, J. S. Cooper, A. R. Wilson, R. A. Greeves.

Assistant Surgeons' Dressers.—Messrs. R. J. Bentley, T. C. Pocock, H. A. Watney, B. B. Metcalfe (Mr. Lane); G. Hamilton, E. H. Adams, E. Bellingham Smith, F. T. H. Wood, G. W. Nicholson (Mr. Dunn); W. P. Purdom, M. Leckie, H. S. Knight, F. A. Sharpe, R. S. Harper (Sir Alfred Fripp); E. F. Milton, T. Norman, H. F. Wight, E. E. Rendle (Mr. Steward).

Medical Ward Clerks.—Messrs. A. G. Jones, E. White, L. H. Burner, J. H. Mayston, G. H. Morris, H. G. Gibson, C. F. Fothergill, A. S. Morton Palmer, E. L. R. Norton, A. W. Eyles, G. N. Bartlett, T. H. Barton, E. M. Harrison, E. C. Lowe, C. C. A. De Villiers, T. F. Wilson, E. Alban, A. W. Berry, J. S. Bookless, P. F. McEvedy, H. F. Vandermin, W. Welchman, G. Wacher, G. G. Timpson, W. H. Trethowan, P. S. Mills, E. Morgan, C. M. Ockwell, S. Reader, C. W. Ponder, A. Walker, W. H. Robinson, A. S. Blundell Bankart.

Assistant Physicians' Clerks.—Messrs. I. R. Cook, T. R. Harvey (Dr. Shaw); R. M. Wingent, W. H. S. Burney (Dr. Bryant); P. C. Litchfield (Dr. Fawcett).

Surgical Ward Clerks.—Messrs. O. C. H. L. Moll, A. Shepperd, G. Cockcroft, P. D. F. Magowan, I. Valerio, H. C. Malleson, H. A. Pallant, H. E. H. Tracy, R. Davies-Colleye, C. W. Greene, J. G. Phillips, H. J. Clarke, B. K. Nutman.

Obstetric Dressers.—Messrs. H. S. Jones, G. H. Rees, E. Lloyd, F. W. Morton Palmer (January 1st); R. D. Bridger, E. C. Myott, F. Rogerson (February 15th).

Aural Surgeon's Dressers.—Messrs. W. N. May, G. F. Hardy.

Post-mortem Clerks.—Messrs. D. Isaacs, A. R. Beaumont, A. S. Littlejohns.

Assistant Surgeon's Clerk.—Mr. W. H. Miller (Mr. Dunn).

CIVIL.

Baker, W. Langworthy, L.R.C.P. Lond., M.R.C.S., has been appointed Assistant Resident Medical Officer at the Toxteth Union Workhouse.

Bruce, H. W., M.D. Lond., F.R.C.S., has been appointed Assistant Medical Superintendent of the Southwark Union Infirmary.

Garner, W. L., M.B., B.C. Cantab., has been appointed District Medical Officer of the Ampthill Union.

Houghton, N. N. A., M.B. Lond., M.R.C.S., L.R.C.P. Lond., has been appointed Assistant House Physician to the General Hospital, Nottingham.

Leader, H., M.B. Lond., M.R.C.S., L.R.C.P. Lond., has been appointed Honorary Assistant Medical Officer to the Sheffield Children's Hospital.

Roberts, J. Lloyd, M.D., B.S., B.A., B.Sc., M.R.C.P. Lond., F.R.C.S. Eng., has been appointed Honorary Physician to the Royal Southern Hospital, Liverpool.

Wacher, H., M.B. Camb., L.R.C.P. Lond., M.R.C.S., has been appointed Second Honorary Physician to the Kent and Canterbury Hospital.

NAVAL AND MILITARY.

Surgeons Guy L. Buckeridge and F. M. Vincent Smith, R.N., have been posted to Haslar Hospital for duty.

Staff-Surgeons J. Dowson, A. G. Wildey, H. R. Osborne, E. R. D. Fasken, W. W. Pryn, W. Bett and J. D. Hughes are promoted to be Fleet-Surgeons.

Surgeons A. E. Kelsey and F. D. Lumley are promoted to be Staff-Surgeons, R.N.

Surgeon-Captain H. M. Brownfield is transferred from the 3rd to the 1st Battalion (Volunteer) the Hampshire Regiment.

Nursing News.

Matron's Office.

On November 4th, Probationer Foskett was appointed Head Nurse in Bright ward.

On November 17th, Nurse Anderson, Head Nurse in Bright, left the Hospital, having completed her three years' training. Probationer Mott was appointed to succeed her as Head Nurse in Bright.

We regret to record the death of Probationer Alice Bailey, who died of typhoid fever in Miriam ward on November 23rd, 1903.

We have much pleasure in announcing that the first course of Post Graduate Lectures, held in connection with the Guy's Hospital Past and Present Nurses' League, has been a great success. The lectures have been printed and sent to subscribers all over England, and also abroad, and the Matron has received numerous letters from the Nurses, saying how much they have been appreciated. The last lecture was given on November 24th, at the close of which a vote of thanks was passed by those present to the Matron for arranging the lectures, and to the lecturers for the trouble they had taken to make them useful to Nurses doing private work. The Matron has a limited number of the printed lectures in hand, and intending subscribers should send in their names immediately if they wish to secure the set.

Change of Address.

Surgeon R. H. B. Hall, from H.M.S. *Edgar*, Holyhead, to H.M.S. *Bramble*, China Station.

Dr. Charles J. Harnett, from Atlas House, The Parade, to The Limes, Hawley Street, Margate.

Dr. S. W. MacIlwaine, from The Lyndens, Redhill, to 26, Westmoreland Road, Bromley, Kent.

Dr. W. C. C. Pakes, from Pretoria, to the Government Laboratories, Hospital Street, Johannesburg.

Dr. J. Lloyd Roberts, from 20, Prince's Avenue, to 68, Rodney Street, Liverpool.

Dr. Frederic G. Vicars, from 22, Ovington Gardens, S.W., to 6, Richmond Hill, Bournemouth.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Sport.

Association Football.

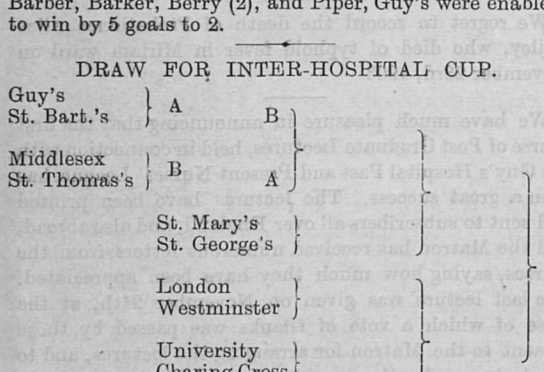
GUY'S v. OLD CARTHUSIANS.

This match was played at Honor Oak Park on Wednesday, December 2nd, when, although the ground was in anything but a good condition, a fast game resulted. At half-time the score was equal, Litchfield doing the needful for Guy's, whilst Ryder scored for the Old Carthusians from a pass close in to goal by Wreford Brown, who was simultaneously appealed against for "hands." Until this Guy's had shown very fine form, but now they apparently went to pieces in face of stronger opposition, the right back making several mistakes at critical moments. Barber scored a second goal, but a few moments later Ryder equalised with a characteristic kick, and, goals being added by Furse, Wreford Brown and Stanborough, the Carthusians won by 7 goals to 2.

GUY'S v. OLD ETONIANS.

The above match took place at Catford on Wednesday, November 28th. Guy's were not quite at full strength, but always held the upper hand. Goals being scored by Barber, Barker, Berry (2), and Piper, Guy's were enabled to win by 5 goals to 2.

DRAW FOR INTER-HOSPITAL CUP.



1st Round to be played by January 31st.
2nd " " February 14th.
3rd " " February 28th.
Final " "

Papers by Guy's Men.

Two Cases Illustrating the Fallacy of certain P' Signs in Diagnosing Perforated Gastric Ulcer. By W. Harland Peake, M.D., B.S.—*British Medical Journal*. November 21st.

A Lecture on the Modification of Cow's Milk for Infant Feeding. By George F. Still, M.A., M.D., F.R.C.P.—*The Clinical Journal*, November 25th.

Management of Epidemic Plague. By J. Ashburton Thompson, M.D., D.P.H. — *The Australasian Medical Gazette* for October, 1903.

On the Number of Nodes of Ranvier in different stages of the growth of Nerve Fibres in the Frog. By A. E. Boycott, M.A., M.B., B.Sc.—*The Journal of Physiology*, December 14th.

Clinical Examination of the Gastric Contents. By Herbert French, M.B., B.Ch. Oxon., M.R.C.P. Lond.—*The Practitioner*, December, 1903.

On Albuminuria as an Accompaniment of Diabetes Mellitus. By F. W. Pavy, M.D. Lond., F.R.S.—*The Lancet*, November 28th and December 5th.

A Lecture on Albuminuria. By P. H. Pye-Smith, M.D., F.R.C.P., F.R.S.—*The Clinical Journal*, December 16th.

A Lecture on the Mental Disorders Associated [illegible] Decay. By G. H. Savage, M.D., F.R.C.P.,—*Practit.* [illegible]*r* for December, 1903.

Diseases of Children : A Review of Recent Work. By George F. Still, M.A., M.D., F.R.C.P.—*Ibid.*

The Bradshaw Lecture on Cancer and its Origin. By Henry Morris, M.A., F.R.C.S.—*British Medical Journal*, December 12th.

A Lecture on Means for the Prolongation of Life. By Sir Hermann Weber, M.D., F.R.C.P.—*British Medical Journal*, December 5th.

Marriages.

COLLIER—LESLIE.—On December 2nd, at Christ Church, Bath, by the Rev. A. E. King, Vicar of St. Philip's, Sydenham, assisted by the Rev. Prebendary Norton Thompson, Henry Nunan Collier, L.S.A. Lond., of Avonmouth, only son of Lieut.-Colonel Hopetoun Currie Collier, R.A.M.C. (retired), of Sydenham, to Annie Eleanor Leslie, eldest daughter of the late George James Leslie, formerly H.B.M. Vice-Consul at Iquique, and Mrs. Leslie, of the Glen, Kirkdale, Sydenham.

KIRKBY—PUGHE.—On the 3rd of December, at St. Cadvans Church, Towyn, Merioneth, by the Rev. Titus Lewis, B.D., Rural Dean, assisted by the Rev. David Pugh, M.A., Robert Casement Kirkby, M.R.C.S., L.R.C.P., 87, Earlsfield Road, Wandsworth Common, third son of the late D. E. Kirkby, Esq., J.P., of Llanfendigaid, Towyn, Merioneth, to Myfanwy Wenona, youngest daughter of the late John Pughe, Esq., J.P., F.R.C.S., of Aberdovey, North Wales.

Ed.—R. E.

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